Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 13, 2015	2015_257518_0039	015741-15	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD SUITE 205 TORONTO ON M6A 1J6

Long-Term Care Home/Foyer de soins de longue durée

Berkshire Care Centre
350 DOUGALL AVENUE WINDSOR ON N9A 4P4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ALISON FALKINGHAM (518)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 16, 2015

This inspection was conducted as a result of a complaint IL 39181-LO regarding dining conditions for residents.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Food Service Manager, the Dietitian, two Registered staff members and six Personal Support Workers. The inspector also observed 12 resident clinical records, two meal services on two floors and homes policies specifically regarding pleasurable dining experience.

The following Inspection Protocols were used during this inspection:
Dining Observation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that included meal service in a congregate dining setting.

A meal service was observed in two areas of the nursing home. During this observation the Inspector noted overcrowding in the dining rooms on the floors, residents eating in the hallways and at the nursing desk.

The Administrator and Director of Nursing as well as the Food Service Manager were aware of the crowding at meal times on the floors.

The Administrator confirmed that the expectation was for all residents to enjoy a pleasurable dining experience in a congregate setting. [s. 73. (1) 3.]

2. The licensee failed to ensure that all residents were monitored during meals, including residents eating in locations other than the dining room.

A meal service was observed in two areas of the nursing home.

Three residents were observed eating their meals in their rooms unsupervised and not visible to staff members in the hallways. These observation were confirmed by the Registered Practical Nurse.

The homes policy FNSM030 indicated that each resident should receive supervision, encouragement and assistance with the intake of food and beverages at mealtime and snack time.
The Nutrition Manager confirmed that no resident should be eating anywhere unsupervised.

The Administrator confirmed the expectation was that all residents would be supervised during meal and snack times. [s. 73. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home has a dining and snack service that includes, at a minimum, meals service in a congregate dining setting unless a resident's assessed needs indicate otherwise and all residents are monitored during meals, to be implemented voluntarily.

Issued on this 24th day of August, 2015

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.