Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 5, 2020	2020_715672_0012	015551-20	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Taunton Mills
3800 Brock Street North WHITBY ON L1R 3A5

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

JENNIFER BATTEN (672)

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): September 10, 11, 14, 15 and 18, 2020

The following intakes were inspected during this Complaint inspection:

One complaint intake received by the Director related to concerns regarding a resident's nutrition and hydration, repositioning and toileting, medication administration and lab work and the internal visitation policy in place as a result of the COVID-19 pandemic.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Recreation Aides (RA), Cooks, Registered Dietitian (RD), Food Services Manager (FSM), Personal Care Aides (PCA), Registered Practical Nurses (RPN), Kinesiologist and residents

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Nutrition and Hydration

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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001's plan of care was provided to the resident as specified in the plan, related to dietary restrictions.

A complaint was received by the Director from a member of resident #001’s family, which included concerns related to the resident’s food and fluid intake. Upon review of nutritional assessments completed by the Registered Dietitian (RD), Inspector #672 noted the resident had documented food intolerances and dislikes. On a specified date, resident #001 was observed during the lunch meal eating a food item listed as an intolerance. During an interview, the RD verified that resident #001 had not received the care as specified in their plan. By not ensuring that resident #001's plan of care was provided as specified, the resident was placed at risk of ingesting a harmful food substance which may have caused the resident to experience a negative reaction.

Sources: Resident #001’s written plan of care, Dietary Profile Assessments-SV1-V2 completed on identified dates, interviews with the RD, Food Services Manager, DOC and resident #001. [s. 6. (7)]

2. The licensee failed to ensure that resident #001 was toileted after lunch, as per their plan of care.

A complaint was received by the Director from a member of resident #001’s family, which included concerns related to resident #001’s toileting schedule, as the resident was frequently not assisted to the toilet after the lunch meal. Upon review of the resident’s current written plan of care, Inspector #672 noted the care plan directed that staff were to assist resident #001 to the toilet after every lunch meal. On an identified date, resident #001 was observed during and after the lunch meal. During the observation, resident #001 was not assisted to the bathroom. During an interview, PCA #102 indicated resident #001 was not assisted to the toilet following the lunch meal that day due to the staff finishing late in the dining room. During an interview, the DOC indicated the expectation in the home was for residents to receive their plan of care as specified and resident #001 should have been toileted following the lunch meal, as directed in their plan of care. By not ensuring that resident #001's plan of care was provided as specified, the resident was placed at risk of being incontinent which could cause the resident to experience physical discomfort, emotional distress or skin breakdown.

Sources: Resident #001’s current written plan of care, MDS assessment, observation completed on an identified date, interviews with the complainant, PCA #102 and the DOC. [s. 6. (7)]

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 that residents receive the care as specified in their plan of care, to be implemented voluntarily.

Issued on this 6th day of October, 2020

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

Original report signed by the inspector.