Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 22, 2013	2013_200148_0009	O-000125-13	Critical Incident System

Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 19 and 20, 2013

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Corporate Regional Representative, Nutritional Manager, Registered Dietitian, Registered Nursing Staff, Personal Support Workers and Food Service Workers.

During the course of the inspection, the inspector(s) reviewed resident health records, interdisciplinary communication tools, shift reports and the food production system (including menus, food production sheets and recipes). The inspector observed meal service and puree product.

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

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.11(2), in that the licensee did not ensured that a resident is provided with texture modified food that was safe.

At the evening meal service on a specified date, Resident #001 subsequently choked on what staff reported as a small chunk of food in the puree texture modified meal.

An interview with the Nutritional Manager and Staff member #S102 responsible for the service and preparation of the supper meal on that date, respectively, describe that puree texture modified foods should be smooth, without lumps, consistent and hold shape.

The puree texture modified food prepared for and provided to Resident #001, was not safe in that it was not a smooth product, without lumps. [s. 11. (2)]

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 are provided with texture modified food that is safe, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6. (4) (a) in that the licensee did not ensured that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

During the evening meal service on a specified date, Resident #001 choked on a small chunk of food in the puree texture modified meal.

The Nutritional Manager (NM), who was serving the evening meal on that date, confirmed that she began meal service at 1700 hours and was present in the kitchen until 1800 hours. The NM stated that she was not informed of the choking incident at the time of meal service.

Communication to the dietary department was provided through an All Staff Memo communication. However, the communication did not include that the resident had choked on food the previous evening.

An interview of the home's Registered Dietitian confirms that the above memo was received. However, she not aware of the resident's choking incident until informed by the Inspector during the this inspection.

No further action was taken related to this written notification as LTCHA 2007, S.O. 2007, c.8, s.6(4)(a), was previously issued during an inspection in November 2012 with a Compliance Order stating:
The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA 2007, S.O. 2007,c.8, s. 6(4) to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. The plan shall include:
1. Clarification of the process by which the Registered Dietitian and Food Service Supervisor are to be notified by nursing staff of changes to resident's health status.
2. Clarification of the process by which the nursing staff (PSW, RPN, RN) communicate amongst themselves any changes or concerns related to residents' nutritional condition/status.

This compliance date for this Order is March 31, 2013. [s. 6. (4) (a)]

Issued on this 22nd day of February, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Amanda Nixon RD LTCH Inspector