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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 1, 2013	2013_191107_0011	H-002211-12, H-000337-13	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

WEST OAK VILLAGE
2370 THIRD LINE, OAKVILLE, ON, L6M-4E2

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

MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

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

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

During the course of the inspection, the inspector(s) spoke with Residents, family members of residents, Registered staff, front line nursing and dietary staff, Nutrition Manager

During the course of the inspection, the inspector(s) Observed the evening meal service in an identified home area, toured the home, inspected all servery areas of the home, reviewed a portion of the clinical health records of all residents in an identified home area, reviewed the home's pest management reports

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (3) The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care. 2007, c. 8, s. 6 (3).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(3)]
The plan of care for two residents did not include all aspects of care, including level of assistance required for eating.
A) Resident #001's plan of care did not include direction for staff related to required level of assistance with eating.
B) Resident #002's plan of care did not include direction for staff related to required level of assistance with eating. The resident was not a recent admission to the home. Staff interview confirmed that level of assistance required for eating was not included in the plan of care for these two residents. [s. 6. (3)]

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 with ensuring that the plan of care for residents includes all aspects of care, including nutritional and dietary care, to be implemented voluntarily.

WN #2: 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. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 73(2)(b)]
Residents who required assistance with eating had their meals placed on the table prior to assistance being provided at the supper meal September 19, 2013.
A) Resident #004 had their hot meal placed on the table prior to 1705 hours and assistance was not provided until 1716. The resident required full assistance from staff with eating.
B) Resident #003 had their hot meal placed on the table prior to 1705 hours and assistance was not provided until 1713. The resident was dependent on staff for eating.
C) Resident #006 had their hot meal placed on the table prior to assistance being provided. The resident sat in-front of their meal not eating until staff came to assist after half an hour. Staff sitting at the table was assisting the other two residents who required assistance with eating prior to assisting this resident.
D) Resident #008 had their meal placed on the table and was not assisted. Staff was at the table, however, was assisting the other two residents at the table. The resident was sleeping at the table until 1726 hours when assistance was provided. The resident had been sitting in-front of their meal for quite some time prior to assistance being provided. The resident's plan of care identified extensive assistance with eating was required. [s. 73. (2) (b)]

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 with ensuring that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 3(1)7]
Not all staff wore or had visible name tags to identify who was providing care to the residents at the supper meal September 19, 2013. Three staff in an identified dining area during the supper meal September 19, 2013, did not have identification to identify who they were and several of the nursing staff on the other floors (noted on home tour) did not have visible identification. The inspector could not identify the staff or their position without asking. [s. 3. (1) 7.]

Issued on this 1st day of October, 2013

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

M Warrener, RD