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
Jan 7, 2014	2014_191107_0001	H-000094-13	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1

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

POST INN VILLAGE
203 Georgian Drive, OAKVILLE, ON, L6H-7H9

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

MICHELLE WARRENER (107)

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): December 3, 4, 5, 2013

During the course of the inspection, the inspector(s) spoke with The Administrator, Nutrition Manager, Personal Support Workers, Dietary Aides, residents

During the course of the inspection, the inspector(s) Observed the evening snack pass in an identified home area and reviewed clinical health records of identified residents

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

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. 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. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
Resident #009 was not provided care consistent with their written plan of care. The resident had a physician order and plan of care that directed staff to provide thickened fluids at meals and snacks. The resident was offered regular (thin) juice at the evening snack December 3, 2013. [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 with ensuring that the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 30(2)]
The provision of snacks in the afternoon and evening, under the Nutrition and Hydration program, was not consistently documented and/or was not documented according to the home's policy which prevented the evaluation of residents' intake at snack time over a 34 day period.
A) Resident #001 did not have their afternoon snack recorded six times and the evening snack was not recorded on 16 occasions.
B) Resident #002 did not have their afternoon snack recorded seven times and the evening snack (food) was not recorded on 14 occasions.
C) Resident #003 did not have their evening snack recorded on 22 occasions.
D) Resident #004 did not have their afternoon snack recorded 11 times and the evening snack was not recorded on 20 occasions.
E) Resident #005 did not have their afternoon snack recorded on 10 occasions and the evening snack was not recorded on 18 occasions.
F) Resident #006 did not have their evening snack recorded on 13 occasions.
G) Resident #007 did not have their afternoon snack recorded on 12 occasions and the evening snack was not recorded on 10 occasions. The resident required a special snack in the evening.
H) Resident #008 did not have their afternoon snack recorded on 24 occasions and the evening snack was not recorded on two occasions.
I) Resident #009 did not have their afternoon snack recorded on 22 occasions.
J) Resident #010 did not have their afternoon snack recorded on 22 occasions.
K) Resident #011 did not have their afternoon snack recorded on 20 occasions and the evening snack was not recorded on 2 occasions.
L) Resident #012 did not have their afternoon snack recorded on 17 occasions.
M) Resident #013 did not have their afternoon snack recorded on 6 occasions and their evening snack was not recorded on 13 occasions.
N) Resident #014 did not have their afternoon snack recorded on 20 occasions. [s. 30. (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 with ensuring that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are to be documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 71(3)(c)]
Not all residents were offered an evening snack on December 3, 2013 on an identified home area.
A) Resident #001, who was at high nutritional risk, was offered a beverage, however, was not offered a snack during the evening snack pass. Documentation on the food and fluid intake records over a 34 day period did not reflect that food was consistently offered to the resident in the evening.
B) Resident #002 was not offered a snack or a beverage. Staff stated the resident received a special item at the supper meal, however, did not offer the resident anything at the snack pass. The resident was at high nutritional risk. Documentation on the food and fluid intake records did not reflect the resident was consistently offered a snack in addition to a beverage at the evening snack.
C) Resident #003 was offered a beverage, however, was not offered a snack. The resident's plan of care stated the resident liked an item similar to the "snack of the day", however, the daily snack was not offered to the resident. The plan of care also indicated a special snack was to be offered to the resident. Documentation on the food and fluid intake records did not reflect the resident was consistently offered a

snack in addition to a beverage at the evening snack.
D) Resident #004 was offered a beverage, however, was not offered a snack. The resident's plan of care stated they liked almost everything and did not have food dislikes. Documentation on the food and fluid intake records did not reflect the resident was consistently offered a snack in addition to a beverage at the afternoon and evening snacks.
E) Resident #005 was offered a beverage, however, was not offered a snack. The plan of care stated the resident was unable to make meal choices. Documentation on the food and fluid intake records did not reflect the resident was consistently offered a snack in addition to a beverage at the afternoon and evening snack.
F) Resident #006 was offered a beverage, however, was not offered a snack. The resident's plan of care directed staff to ensure to offer food at snacks as the resident may not say that they are hungry. Documentation on the food and fluid intake records did not reflect the resident was consistently offered a snack in addition to a beverage at the evening snack.
G) Resident #007 was not offered a beverage or a snack. The resident had a plan of care that directed staff to provide a special beverage at the evening snack pass and a hydration plan that required an additional beverage to be offered at snacks. Documentation on the food and fluid intake records did not reflect the resident was consistently offered a snack in addition to a beverage at the afternoon and evening snacks.
H) Resident #008 was offered a beverage, however, was not offered a snack. The resident's plan of care stated they were unable to make meal choices. Documentation on the food and fluid intake records did not reflect the resident was consistently offered a snack in addition to a beverage at the afternoon and evening snacks.
I) Resident #009 was offered a beverage, however, was not offered a snack. The resident's plan of care stated the resident was unable to make food choices. Documentation on the food and fluid intake records did not reflect the resident was consistently offered a snack in addition to a beverage at the afternoon and evening snacks.
J) Resident #010 was offered a beverage, however, was not offered a snack. The resident had a history of weight loss. Documentation on the food and fluid intake records did not reflect the resident was consistently offered a snack in addition to a beverage at the afternoon and evening snacks.
K) Resident #011 was not offered a beverage or a snack. The resident's plan of care stated they were prone to suboptimal fluid intake, had a history of significant weight loss, at high nutritional risk and directed staff to assist and encourage intake at snacks. Documentation on the food and fluid intake records did not reflect the resident

was consistently offered a snack in addition to a beverage at the afternoon and evening snacks.
L) Resident #012 was not offered a beverage or a snack from the snack cart. Staff stated the resident would receive a supplement from the nurse at a later time, however, no snack from the cart was offered to the resident. The resident's plan of care stated the resident had a poor appetite and directed staff to utilize creative strategies, including offering fluids that were generally available on the snack cart. The plan of care also indicated the resident was to be offered a special beverage at snacks. Documentation on the food and fluid intake records did not reflect the resident was consistently offered a snack in addition to a beverage at the afternoon and evening snacks. [s. 71. (3) (c)]

2. [O.Reg. 79/10, s. 71(4)]
Not all of the planned menu items were offered and available at the evening snack pass December 3, 2013.
A) The planned menu for the evening snack pass December 3, 2013 required a pureed peanut butter and jam sandwich, however, the pureed sandwich was not available on the cart and not offered to residents on the home area reviewed. Staff confirmed that the sandwich was prepared, however, was not placed on the cart and not offered to residents. Two residents on the identified home area required a pureed menu. [s. 71. (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 with ensuring that each resident is offered a snack in the afternoon and evening (r. 71(3)(c) and ensuring that the planned menu items are offered and available at each meal and snack r. 71(4), to be implemented voluntarily.

Issued on this 7th day of January, 2014

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