

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 Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office 347 Preston St, 4th Floor OTTAWA, ON, L1K-0E1 Telephone: (613) 569-5602 Facsimile: (613) 569-9670 Bureau régional de services d'Ottawa 347, rue Preston, 4iém étage OTTAWA, ON, L1K-0E1 Téléphone: (613) 569-5602 Télécopieur: (613) 569-9670

## Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	•	Type of Inspection / Genre d'inspection
Sep 24, 2014	2014_236572_0018	563-14, 660- 14, 816-14	Complaint

### Licensee/Titulaire de permis

AON INC.

33 HARBOUR SQUARE, SUITE 825, TORONTO, ON, M5J-2G2

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

MOIRA PLACE LONG-TERM CARE HOME

415 RIVER STREET WEST, TWEED, ON, K0K-3J0

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

BARBARA ROBINSON (572), JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection



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

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

This inspection was conducted on the following date(s): August 26, 27, and 28, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses(RPN), Personal Support Workers (PSW), the Dietary Manager and Dietary aides, a Physiotherapist, a Physiotherapist's Assistant, and residents.

During the course of the inspection, the inspector(s) observed resident care and services including dining, reviewed resident health care records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.



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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES				
Legend	Legendé			
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.			
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 has failed to comply with LTCHA 2007, s. 6(7) in that the care set out in a resident's plan of care was not provided to the resident as specified in the plan.

On a specified date, Resident #4 choked on his/her scrambled eggs at the breakfast meal. Resident #4 had a diet order for a regular, pureed diet at the time of this incident.



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

The Registered Dietitian documented the following in the progress notes on a specified date:

- Heard resident coughing this morning during breakfast - he/she appeared to be choking on his/her eggs. Noted that texture was very dry and crumbly. Discussed with DA (dietary aid) as to the need for puree to be moist and smooth. Eggs were removed and he/she was provided with yogurt instead which was tolerated very well. Plan: Will pass concerns re texture modification along to the Director of Dietary Services

RN #S107 documented the following in the progress notes on February 13, 2014: - Dietitian stated the eggs were not pureed as they should have been, but were dry and crumbly. Dietary aide was notified that he/she needs pureed eggs by Dietitian.

In an interview on August 28, 2014, the Registered Dietitian stated that no other resident had an issue that day with the pureed eggs and that this has not been a recurring problem. [s. 6. (7)]

- 2. A review of the health care record for Resident #1 indicates that he has multiple comorbidities and that he requires a specified treatment. The health care record for Resident #1 states that the resident did not received this treatment as ordered and specified in the plan of care on four occasions.
- 3. In an interview on August 25, 2014, a relative of Resident #1 stated that on a specified date the resident had the wrong cream applied by PSW #S108 and it irritated the resident's skin.

The initial plan of care for Resident #1 stated that he was to have a specified cream applied. RPN #S103 stated on August 27, 2014, that PSWs are allowed to apply two topical creams in the home. RPN #S103 confirmed that on a specified date a PSW applied the wrong cream to Resident #1, resulting in skin irritation. On a specified date, RN #S107 documented that PSW #S108 applied the wrong cream to Resident #1.

On August 28, 2014 the DOC confirmed that PSW #108 applied the wrong cream to Resident #1 and washed it off after realizing the mistake. Resident #1 did not receive care as specified in the plan of care. [s. 6. (7)]



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

### 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 the care set out in a resident's plan of care is provided to the resident as specified in the plan., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants:



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

1. The licensee has failed to comply with O. Reg. 79/10, s. (2)(c) in that there are not standardized recipes for all menus.

On a specified date, Resident #4 choked on the pureed scrambled eggs at the breakfast meal. The Registered Dietitian stated in an interview on August 28, 2014 that he/she observed the scrambled eggs that day to be dry and crumbly and said that more fluid should have been added to make the texture moist and smooth as a puree should be.

On August 28, 2014, during an interview with the Director of Dietary Services, it was noted that there are standardized recipes for all texture modified lunch and supper items, but not for breakfast items. The recipe sheet for scrambled eggs was reviewed specifically, and there is no recipe or instructions directing the Dietary Aides on how to properly prepare the minced or pureed scrambled eggs. The Director of Dietary Services further stated during this interview that the Dietary Aide S#108 who was working during the incident is very conscientious, however, typically worked the afternoon shift and would not normally have to complete texture modification of the breakfast items that do not have standardized recipes.

On August 28, 2014, Dietary Aide #S111 stated that he/she has worked the day shift for years and does not have a problem reaching the appropriate texture for the pureed breakfast items. He/she recognized that there was no standardized recipe for the scrambled eggs and stated that he/she just adds small amounts of fluid at a time until the desired consistency is reached. [s. 72. (2) (c)]

Issued on this 24th day of September, 2014

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