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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 13, 2016	2016_457630_0014	012854-16	Complaint

Licensee/Titulaire de permis

PEOPLECARE Inc.
28 William Street North P.O. Box 460 Tavistock ON N0B 2R0

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

PEOPLECARE OAKCROSSING LONDON
1242 Oakcrossing Road LONDON ON N6H 0G2

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

AMIE GIBBS-WARD (630)

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): May 6, 2016

This inspection was conducted for complaint Log #012854-16 related to dining

During the course of the inspection, the inspector(s) spoke with the Executive Director, two Assistant Directors of Care, the Assistant Food Services Manager, one Registered Nurse, three Personal Support Workers, one Dietary Aide, residents and families.

The inspector also observed meal service in one resident area, reviewed health care records for identified residents, reviewed policies and procedures of the home and reviewed staffing schedules for a specified resident area.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	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. The licensee has failed to ensure the plan of care for eating and resisting care was provided to the resident as specified in the plan.

Observations in the dining room during a lunch meal found an identified resident was not in the dining room at any time during the meal service and had not received a meal.

Interview with a Dietary Aide confirmed that this resident was not in the dining room during the lunch meal and had not received a meal during the regular meal service.

Interview with a Personal Support Worker (PSW) indicated that this resident did not respond when asked to go to the dining room and that this resident was not re-approached or offered food or fluids during the meal service.

The clinical record for this identified resident showed that this resident needed supervision and cueing at meals and if care was refused staff were to re-approach after 15 minutes.

Interview with an Assistant Director of Care (ADOC) acknowledged it was the expectation of the home that this resident would be reproached and encouraged by staff to attend the dining room during meals. [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 the 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. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**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. The licensee has failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

Observations during a lunch meal service found that multiple residents in an identified dining room were not served their meals course by course.

Observations of two identified residents found they were served their main entrée while their soup was still sitting in front of them untouched. In each case a PSW pushed the soup away from the resident when serving the meal entrée and was not observed to provide cues or encouragement to the resident and they did not consume their soup. These two residents were also observed to be served their dessert prior to completing the main entrée.

Review of the plan of care for these residents found that it was not identified as an assessed need that meals would not be served course by course.

Observations of another identified resident found that a PSW added the dessert on the plate for the main entree that the resident was eating.

Interview with the Assistant Food Services Manager acknowledged that the residents were not being served the meals course by course. The Assistant Food Services Manager indicated it was the expectation in the home that meals would be served course by course in this dining room and that dessert items would not be added to the plate of a main entree.

Interview with the Executive Director on May 6, 2016 acknowledged that it was an expectation in the home that meals would be served course by course. [s. 73. (1) 8.]

2. The licensee has failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

a) Observations during a lunch meal service found an identified resident was served fluids and food prior to receiving the assistance required with eating and drinking.

Review of the plan of care for this identified resident showed that this resident required assistance with eating and drinking.

b) Observations during a lunch meal service found another identified resident was served fluids and food prior to receiving the assistance required with eating and drinking.

Review of the plan of care for this identified resident showed that this resident required assistance with eating and drinking.

Interview with a Registered Nurse (RN) indicated that in this specific dining room there was only 25 per cent of residents able to feed themselves without some level of assistance at meals.

Interview with the Executive Director (ED) and the Assistant Food Services Manager acknowledged this identified dining room was challenging at mealtimes as there were multiple residents who required assistance, who tended to wander at meals and who had responsive behaviours. The ED and AFSM acknowledged that it was the expectation in the home that residents would receive the assistance they required at meals which included not serving food items until someone was available to provide the assistance 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 meals are served course by course and that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance, to be implemented voluntarily.

Issued on this 13th day of May, 2016

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

Original report signed by the inspector.