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

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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
Feb 18, 2015	2015_108110_0002	T-617-15	Complaint

Licensee/Titulaire de permis

Downsview Long Term Care Centre Limited
3595 Keele Street NORTH YORK ON M3J 1M7

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

Downsview Long Term Care Centre
3595 Keele Street NORTH YORK ON M3J 1M7

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

DIANE BROWN (110), SUSAN SQUIRES (109)

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): January 16, 20, 21, 23, February 3 and 4, 2015

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC) assistant director of care, clinical coordinator, registered dietitian(s)(RD), registered nurses, food service manager, food service worker, personal support workers

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **2 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #01 received a skin assessment by a member of the registered nursing staff within 24 hour of admission to the home.

Record review of the CCAC application for admission identified the resident to be at risk for altered skin integrity. Resident #01 was admitted to the home on an identified date. Review of the admission summary note revealed that the section for Head to Toe Assessment was not completed. Further review of the skin assessments and head-to-toe bath assessment revealed the resident was not assessed by a member of the registered nursing staff within 24 hours of admission to the home. This was confirmed with a manager. [s. 50. (2) (a) (i)]

2. The licensee failed to ensure that resident's exhibiting altered skin integrity, including

skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The home has a clinically appropriate assessment instrument which according to the DOC is to be implemented for all alterations in skin integrity.

Record review and staff interview revealed resident #01 exhibited recurring altered skin integrity. On an identified date two areas of altered skin integrity were discovered. Three weeks from the identified date, a progress note describes an area of altered skin integrity; a further seventeen days later, the altered skin integrity had worsened. On an identified date, approximately three months from when the initial areas of altered skin integrity were discovered, a new area of altered skin integrity was found. A few days later the area had progressed and a few weeks later it had progressed even further.

The assessment for resident #01's area of altered skin was not completed using the homes skin assessment tool until four months after the initial identified two altered areas. [s. 50. (2) (b) (i)]

3. Record review and staff interview revealed resident # 2 had altered skin integrity. The resident further sustained a secondary skin alteration. Neither of these alterations in skin integrity were assessed using the homes skin assessment tool.

4. Record review and staff interview revealed resident #3 had altered skin integrity. Review of the wound management treatment plan and weekly assessment instrument revealed the wounds were not assessed using the home's assessment tool.

5. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wound have been assessed by a registered dietitian who is a member of the staff of the home.

Record review and staff interviews identified that resident #01 had an area of altered skin integrity, on an identified date, which progressed seventeen days later, and was not referred to the registered dietitian. The registered dietitian acknowledged the altered skin integrity at a quarterly review, four weeks after the initial area of altered skin integrity was identified. The residents' area of altered skin integrity progressed further.
The clinical coordinator confirmed that a referral to the registered dietitian should have

been initiated when the area of altered skin integrity was first identified. [s. 50. (2) (b) (iii)]

6. The licensee failed to ensure that resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds, were reassessed at least weekly by a member of the registered nursing staff.

Record review and staff interviews revealed resident #01 had altered skin integrity since at least two months after admission, as noted on the progress notes. Review of the progress notes on an identified date, approximately three months later, when the resident was transferred to the hospital, indicated there was no weekly assessment completed by a member of the registered nursing staff on the altered area for six identified weeks[s. 50. (2) (b) (iv)]

7. Record review and staff interview revealed resident #02 had an altered area of skin integrity for over a year. Record review and staff interview further revealed that resident #02 did not receive weekly skin assessments for his/her altered areas on two identified weeks, by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

8. Record review and staff interview revealed resident #03 had multiple areas of altered skin integrity since an identified date. Record review and staff interview further revealed that the altered areas were not assessed weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the hydration program includes the identification of any risks related to hydration and that there is clear direction to identify when a resident has not been consuming enough fluids.

Resident #01 admitted on an identified date and was identified at dehydration risk related to use of a medication intended to promote fluid loss. The residents' assessed fluid need was determined by the registered dietitian as greater than 1500mls per day.

Record review revealed that the home inconsistently monitored resident #01's fluid intake but when monitored and totaled the residents' average intake ranged between approximately 1100 - 500mls per day for five consecutive months. Record review further identified that for eight consecutive days, in the month following admission, resident #01's daily fluid intake was recorded in to be less than 900mls per day.

The resident was hospitalized months following admission to the home, and the hospital consultation report identified that resident #01 presented with severe volume depletion, due to a poor oral intake, compounded by an ongoing administration of an identified

medication, which is intended to promote fluid loss.

Policy on Nutrition and Hydration flow sheets stated when a resident's intake is less than 1500mls the RD is to be notified.
Hydration Policy FN-IV-150 Effective Date Sept 2013.
"A resident who consistently drinks less than 900cc(mls)over seven days should be referred to the RN/RPN, MD and RD for follow up assessment for inadequate fluid intakes given risk for dehydration associated with this".

An interview with a registered staff revealed that resident #01 was at high risk for dehydration and that anything under 400-500mls during a day shift would trigger a referral to the RD; another registered staff, whom also identified the resident at high risk for dehydration, revealed that there was no specific fluid intake that would trigger a referral to the RD, but stated "when we need to refer to the dietitian we do".

An interview with the RD revealed that referrals related to poor fluid intake were not received for resident #01. Record review failed to identify that the MD was notified of residents' ongoing poor fluid intake for the eight consecutive days in an identified month and poor fluid intake in the two months that followed.

An interview with the clinical coordinator revealed that nursing staff "did not connect the dots" related to hydration monitoring and assessment for resident #01. [s. 68. (2) (b)]

2. The licensee has failed to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Resident #01 was admitted on an identified date, and identified by the RD at high nutritional risk, in part related to residents' 50-100 per cent intake and need for extensive encouragement at meals.

Interviews with PSW's identified that staff monitor resident's food and fluid intake by documenting food and fluid taken for each meal and snack on the nutrition and hydration flow sheet. Registered nursing staff confirmed that PSW's are expected to document on the flow sheets. The clinical care co-ordinator identified that registered staff are expected to total and monitor residents fluid intake daily and initial the flow sheet. An interview with a registered staff revealed an unawareness of the requirement to review and initial the flow sheets.

Record review revealed that the nutrition and hydration flow sheets were incomplete. In month A, the month the resident was admitted, 28/28 days intake documentation was incomplete and 15/31 days there was no evidence of registered staff initials.
Month B, 19/31 days intake documentation was incomplete and 22/28 days there was no evidence of registered staff initials.
Month C, 25/30 days intake documentation was incomplete and 20/30 days there was no evidence of registered staff initials.
Month D, 12/31 days intake documentation was incomplete and 16/31 days there was no evidence of registered staff initials.
Month E, 5/30 days intake documentation was incomplete and 25/30 days there was no evidence of registered staff initials.

An interview with the clinical coordinator confirmed that PSW's have not been monitoring resident #01's intake by completing the nutrition and hydration flow sheets for all meals and snacks and that registered staff have not been evaluating resident's intake as required.

Resident #01 has experienced ongoing significant weight loss and was assessed five months later, with severe volume depletion requiring rehydration. [s. 68. (2) (d)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy put in place is complied with.
The home's policy #NM-II-W015 titled Weight Management states that any unplanned significant changes will be evaluated using a coordinated interdisciplinary approach and the registered nursing staff will:
-report the residents with significant weight changes to the RD;
-arrange a monthly meeting with the RD to investigate the reason for the weight change and to collaborate on a plan of action to manage the weight; and
-document on the resident's plan of care and on the individual weight record, the observations/findings related to the weight change and any planned interventions.

Record review and interviews with the RD and registered staff revealed that resident #01 had significant weight loss in the first month of his/her admission and ongoing significant weight loss for the following three consecutive months, that were not assessed using a coordinated interdisciplinary approach. Record review and interviews revealed that registered nursing staff do not report or refer significant weight changes to the RD nor do they meet monthly or document on the resident's plan of care regarding weight management.
An interview with clinical coordinator confirmed that nursing had not referred to the dietitian or assessed residents' ongoing weight loss and that the home's policy had not been followed.

The home's policy #NM-II-D010 entitled Dehydration states that the RN/RPN will:
- Assess residents at risk for dehydration, including but not limited to the following conditions: diarrhea or vomiting for more than 24 hours, fever, diaphoresis, poor urinary output, abdominal pain, constipation, poor skin turgor, listlessness, sunken eyes, dry mouth and pallor.
-Report to interdisciplinary care team, any residents identified to be at risk for dehydration and initiate a Fluid intake and Output record.
-Obtain a physician's order for treatment and/or referral, e.g. hypodermoclysis, intravenous therapy.
-Transcribe physician's order onto the MAR. Designate a schedule for offering fluids according to the order and resident's routine activity. Consult registered dietitian for recommended total amount of fluids to provide
-Notify the family regarding the resident's condition and help develop the plan of treatment.
-Document observations, assessment, action taken and resident total intake and output

in the progress notes.
-Develop an individualized plan of care to be reviewed at least weekly or when the resident's condition changes.
-Monitor the resident closely at every shift and document on the progress notes for signs of dehydration. Report findings to the physician if resident's condition has not improved or worsened.

Record review identified that resident #01's was at dehydration risk related to the use of an identified medication intended to promote fluid loss. Staff interviews and record review revealed that the resident was at further risk of dehydration related to poor fluid intake. On an identified date, a progress note entered by an identified registered nurse described the appearance of the resident.
Interview with the registered staff who had observed the resident and transcribed the note confirmed that the resident was dehydrated. Record review and staff interviews revealed that following this observation that there were no referrals to the interdisciplinary team or fluid intake and output records initiated. There was no physician order for treatment or referral. No schedule for offering fluids or consultation with the registered dietitian. There was no evidence that family assistance was obtained in the development of the plan of treatment. Residents' total intake and output were not documented in the progress notes. There was no monitoring of resident #01 with signs for dehydration documented in the progress notes or evidence that findings of the residents' condition were reported to the physician.

The resident was hospitalized one month following the progress note entry and the hospital consultation report identified that resident #01 presented with severe volume depletion, due to a poor oral intake, compounded by ongoing medication administration, which is intended to promote fluid loss. [s. 8. (1) (a),s. 8. (1) (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 to ensure that the home's policy related to weight management and dehydration put in place are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the registered dietitian who is a member of the staff of the home assess the resident's hydration status, and any risks related to hydration.

Resident #01 was reassessed by the RD, on an identified date, at the quarterly nutrition review. At this time, the resident had developed an area of altered skin integrity.
Staff interviews and record review revealed that residents' fluid intake was poor and was identified at dehydration risk related to use of a medication, intended to promote fluid loss .

An interview with the home RD's revealed that the residents' hydration needs would be increased related to the presence of an area of altered skin integrity.
Record review and RD interview confirmed that she had not calculated resident #01's fluid needs based on the resident's altered skin integrity which presented an additional risk to resident #01's hydration status.

The resident was hospitalized two months later, and the area of altered skin integrity had worsened. The hospital consultation report identified that resident #01 presented with severe volume depletion, due to a poor oral intake, compounded by ongoing identified medication administration, intended to promote fluid loss. [s. 26. (4) (a),s. 26. (4) (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 to ensure that the registered dietitian who is a member of the staff of the home assess the resident's hydration status, and any risks related to hydration, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that a resident with the following weight changes is assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.

Resident #01 was admitted on an identified date and identified at high nutritional risk. Record review revealed that the resident had a 5 per cent body weight loss in the first month of admission; a 7.5 per cent body weight loss in the second month, and a 5 per cent body weight loss in the third month. This weight change further triggered a 7.5 per cent body and 10 per cent body weight loss over 3 months.
Resident #01's weight further decreased in the fourth month representing a 7.5 per cent body weight loss and 10 per cent body weigh loss.

An interview with the home's registered dietitian and record review confirmed that she had not assessed resident #01's weight loss in the first and second month since admission with action taken and outcomes evaluated.
Record review and an interview with registered nursing staff and the clinical coordinator confirmed that nursing had not assessed and documented the significant weight loss resident #01 experienced monthly, with actions taken and outcomes evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 to ensure that a resident with the following weight changes is assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months, to be implemented voluntarily.

WN #6: 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Staff interviews confirmed that resident #01's family requested a specialized diet for his/her mother, as the resident ate this food prior to admission.
Record review revealed that on an identified date, a registered nursing staff reported that resident #01's family stated the resident prefers this specialized food and requested this diet to be provided. The same record revealed that a referral was sent to the RD for assessment.

A review of RD referrals and interviews with the RD and food service manager confirmed that a referral was not received related to resident #01 family request for specialized food and that there was a lack of collaboration between the nursing and dietary department. [s. 6. (4) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other.

Record review identified that the registered dietitian completed an admission nutrition assessment on an identified date, related to resident #01. The assessment identified the resident at high nutritional risk and that the resident had two small areas of altered skin integrity.
The interventions identified included nursing staff to inform the RD regarding the residents' areas of altered skin integrity once the MD had assessed them.
An interview with the registered dietitian and food service manager confirmed that nursing had not informed the RD regarding the residents' area of altered skin integrity until four months later when the residents' area of altered skin integrity had progressed.
Record review and interview with the clinical coordinator revealed that resident #01's area of altered skin integrity should have been referred on the initial identified date. [s. 6. (4) (b)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other.

Staff interview and record review identified that resident #01 ate specialized food prior to being admitted to the home. Resident was known by staff to have poor intake and was identified at high nutritional risk. The resident's plan of care directed staff to provide a regular diet and to encourage an intake of identified foods to improve the residents' nutritional status.
An interview with a food service worker and a PSW revealed that a member of the resident's family wanted the resident to have a specialized diet and that they had served a specialized diet to the resident #01. The diet served was not in keeping with the plan of care direction to encourage an intake of identified foods.

An interview with the food service manager confirmed that he/she had not been notified of the families request for specialized foods and that this decision should be verified, assessed and written as part of the resident's plan of care. The interview confirmed a breakdown in communication and a lack of collaboration between the dietary and nursing departments in the development and implementation of the plan of care for resident #01.

[s. 6. (4) (b)]

4. The licensee failed to ensure that when a resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, that different approaches been considered in the revision of the plan of care.

Resident #01 was admitted on an identified date, assessed by the registered dietitian a few days later, and determined to require an estimated amount of fluids at greater than 1500mls per day. At this time, the RD identified that the resident was consuming an average of 900-1300mls per day and on an identified medication to promote fluid loss. The plan of care included staff to encourage the resident to ensure greater than 75% meal and snack completion.
At the quarterly nutrition assessment three months later, the RD identified that the resident consumed 900-1300mls per day; has had a significant weight loss of 11.2% in 3 months due to poor intake and an area of altered skin integrity.
Record review identified the resident remained on the identified medication and had an average fluid intake of 865mls per day in the month of admission and a range of approximately 1000-500mls per day in the following consecutive three months.
Staff interviews identified that the resident needed encouragement to eat and drink and drank better than she/he ate.

Record review and staff interviews revealed that different approaches were not considered in the revision of the resident's plan of care related to hydration.

The resident was hospitalized five months after admission, and the hospital consultation report identified that resident #01 presented with severe volume depletion, due to a poor oral intake, compounded by an ongoing identified medication administration, intended to promote fluid loss. [s. 6. (11) (b)]

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

Issued on this 19th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110), SUSAN SQUIRES (109)
Inspection No. / No de l'inspection :	2015_108110_0002
Log No. / Registre no:	T-617-15
Type of Inspection / Genre d' inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 18, 2015
Licensee / Titulaire de permis :	Downsview Long Term Care Centre Limited 3595 Keele Street, NORTH YORK, ON, M3J-1M7
LTC Home / Foyer de SLD :	Downsview Long Term Care Centre 3595 Keele Street, NORTH YORK, ON, M3J-1M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christiana Burns

To Downsview Long Term Care Centre Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

O.Reg. 79/10 s. 50(2)(b)(i) and 50(2)(b)(iv) has been the subject of a previous non-compliance with voluntary plan of corrective action to the licensee (inspection #2014_163109_0013 from May 23, 2014).

The licensee shall prepare, submit and implement a plan outlining how the home will ensure the following areas are addressed:

1. Skin assessments are completed by a member of the registered nursing staff,using the home's clinically appropriate assessment instrument that is specifically designed for skin and wound for resident #2 and #3 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

2. Weekly assessments are conducted by a member of the registered nursing staff for resident #2 and #3 who are exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff.

Please submit the compliance plan to susan.squires@ontario.ca by February 27, 2015.

Grounds / Motifs :

1. Record review and staff interview revealed resident #03 had multiple areas of altered skin integrity since an identified date. Record review and staff interview further revealed that the altered areas were not assessed weekly by a member of the registered nursing staff. (109)

2. Record review and staff interview revealed resident # 2 had altered skin integrity. The resident further sustained a secondary skin alteration. Neither of these alterations in skin integrity was assessed using the homes skin assessment tool. (109)

3. The licensee failed to ensure that resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The home has a clinically appropriate assessment instrument which according to

the DOC is to be implemented for all alterations in skin integrity.

Record review and staff interview revealed resident #01 exhibited recurring altered skin integrity. On an identified date two areas of altered skin integrity were discovered.
Three weeks from the identified date, a progress note describes an area of altered skin integrity; a further seventeen days later, the altered skin integrity had worsened. On an identified date, approximately three months from when the initial areas of altered skin integrity were discovered, a new area of altered skin integrity was found. A few days later the area had progressed and a few weeks later it had progressed even further.

The assessment for resident #01's area of altered skin was not completed using the homes skin assessment tool until four months after the initial identified two altered areas.

(109)

4. Record review and staff interview revealed resident #03 had multiple areas of altered skin integrity since an identified date. Record review and staff interview further revealed that the altered areas were not assessed weekly by a member of the registered nursing staff. (109)

5. Record review and staff interview revealed resident #02 had an altered area of skin integrity for over a year. Record review and staff interview further revealed that resident #02 did not receive weekly skin assessments for his/her altered areas on two identified weeks, by a member of the registered nursing staff. (109)

6. The licensee failed to ensure that resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds, were reassessed at least weekly by a member of the registered nursing staff.

Record review and staff interviews revealed resident #01 had altered skin integrity since at least two months after admission, as noted on the progress notes. Review of the progress notes on an identified date, approximately three months later, when the resident was transferred to the hospital, indicated there was no weekly assessment completed by a member of the registered nursing

staff on the altered area for six identified weeks

(109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 10, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan outlining how the home will ensure the following areas are addressed:

1. The hydration program includes the identification of any risks related to hydration and the implementation of interventions to mitigate and manage the risks.

2. Education to all direct care staff on the home's policy related to identifying risks to residents' hydration and the implementation of interventions to mitigate and manage the risks.

Please submit compliance plan to Diane.Brown@ontario.ca by February 27, 2015.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the hydration program includes the identification of any risks related to hydration and that there is clear direction to identify when a resident has not been consuming enough fluids.

Resident #01 admitted on an identified date and was identified at dehydration risk related to use of a medication intended to promote fluid loss. The residents' assessed fluid need was determined by the registered dietitian as greater than 1500mls per day.

Record review revealed that the home inconsistently monitored resident #01's fluid intake but when monitored and totaled the residents' average intake ranged between approximately 1100 - 500mls per day for five consecutive months. Record review further identified that for eight consecutive days, in the month following admission, resident #01's daily fluid intake was recorded in to be less than 900mls per day.

The resident was hospitalized months following admission to the home, and the hospital consultation report identified that resident #01 presented with severe volume depletion, due to a poor oral intake, compounded by an ongoing administration of an identified medication, which is intended to promote fluid loss.

Policy on Nutrition and Hydration flow sheets stated when a resident's intake is less than 1500mls the RD is to be notified.
Hydration Policy FN-IV-150 Effective Date Sept 2013.
"A resident who consistently drinks less than 900cc(mls)over seven days should be referred to the RN/RPN, MD and RD for follow up assessment for inadequate fluid intakes given risk for dehydration associated with this".

An interview with a registered staff revealed that resident #01 was at high risk for dehydration and that anything under 400-500mls during a day shift would trigger a referral to the RD; another registered staff, whom also identified the resident at high risk for dehydration, revealed that there was no specific fluid intake that would trigger a referral to the RD, but stated "when we need to refer to the dietitian we do".

An interview with the RD revealed that referrals related to poor fluid intake were

not received for resident #01. Record review failed to identify that the MD was notified of residents' ongoing poor fluid intake for the eight consecutive days in an identified month and poor fluid intake in the two months that followed.

An interview with the clinical coordinator revealed that nursing staff "did not connect the dots" related to hydration monitoring and assessment for resident #01. [s. 68. (2) (b)]

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 24, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu' il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

Service Area Office /
Bureau régional de services : Toronto Service Area Office