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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 20, 2013	2013_306510_0003	S-000389-13	Complaint

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST
400 Olive St., NORTH BAY, ON, P1B-6J4

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

CASSELLHOLME
400 OLIVE STREET, NORTH BAY, ON, P1B-6J4

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

IRENE PASEL (510)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): December 9, 10 and 11, 2013

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Director of Clinical Services(DOC), Registered Nurses/Supervisors of Clinical Services (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW)

During the course of the inspection, the inspector(s) conducted a walk through of the home areas and various common areas, observed care provided to residents of the home, reviewed resident health care records, policies and procedures, and program documents.

The following Inspection Protocols were used during this inspection:
Hospitalization and Death
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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.) 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to

the resident as specified in the plan.

A. The health care record for resident 001 provided by the home for the inspection, identified that resident 001 was at risk for fluid imbalance and recommended a daily fluid intake of 1500-1700 mls.
B. There was no documented evidence of intake and output measurement in the health care record.
C. Staff #103 provided a food intake record when asked about intake and output records. She acknowledged there was no place to record volume of fluids and no place to record output.
D. The CEO provided a Point of Care (POC) intake record that revealed fluid intake was below recommended volumes for fifteen (15) of the twenty (20) days documented. There was no POC output record provided which is necessary to assess fluid imbalance.
E. Resident Care Notes reported staff were unable to obtain a urine sample, even with catheterization.
F. There was intermittent documentation about difficulty in obtaining a urine sample from resident 001 and the resident's discomfort on voiding. There was no assessment of this finding as it related to fluid imbalance. There were no interventions identified to address the reported symptoms.
G. Resident Care Notes reported the resident was not eating and not drinking well, and had experienced significant weight loss in the past month.
H. Resident Care Notes reported poor skin turgor.
I. Documentation described a significant change in the resident's condition and she was transferred to hospital where she was admitted.
J. In the consultation report from the hospital, the MD reported that he thought resident 001 was severely dehydrated given the rise in her creatinine and the fact that it had come back down to just below 200 since admission.
K. The licensee did not ensure that the care set out in the plan of care, specifically related to fluid intake, was provided to resident 001 as specified in the plan. [s. 6. (7)]

2. The licensee did not ensure that the provision of care set out in the plan of care was documented.

A. The care plan identified resident 001 was at risk for fluid imbalance characterized by fluid volume deficit and recommended as an intervention, a daily fluid intake of 1500-1700 mls.
B. Review of health care records revealed the absence of documentation of fluid

intake and output monitoring.
C. The CEO advised fluid intake and output monitoring was part of Point of Care (POC) documentation and provided two documents. These documents revealed intake was documented for twenty (20) days. On fifteen (15) of these days, the fluid intake was below that recommended in the care plan. There was no evidence of any output documentation which is required to determine fluid balance/imbalance.
D. There was intermittent documentation about difficulty in obtaining a urine sample from resident 001 and the resident's discomfort on voiding. There was no documented assessment of this finding as it relates to fluid imbalance. There were no interventions documented to address this finding.
E. The care plan for resident 001 identified a risk for fluid imbalance. Incomplete documentation of the residents daily fluid intake and output did not support ongoing assessment of the resident's condition. [s. 6. (9) 1.]

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 the care set out in the plan of care is provided to all residents as specified in the plan and that the care provided is documented in the health care record, to be implemented voluntarily.

Issued on this 24th day of December, 2013

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

Irene Pasel