Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 2, 3, 7, 8, 9, 15, 16, 20, Sep 5, 11, 12, 2012	2012_108110_0012	Follow up

Licensee/Titulaire de permis

COLLINGWOOD NURSING HOME LIMITED
250 CAMPBELL STREET, COLLINGWOOD, ON, L9Y-4J9

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

COLLINGWOOD NURSING HOME
250 CAMPBELL STREET, COLLINGWOOD, ON, L9Y-4J9

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

DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the inspector(s) spoke with Director of Care, Registered Dietitian, Food Service Supervisor, Registered Staff, Nurse Manager, Personal Support workers, Food Service Workers, Residents

During the course of the inspection, the inspector(s) Reviewed resident clinical records and home policies related to Nutritional Care. Observed meal and snack service to residents.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration

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 subsections:

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. (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
(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 did not ensure that care set out in resident A's plan of care was provided to resident's as specified in her/his plan.
Resident A is at high nutritional risk and requires a specific daily fluid goal.
Interviews with staff and confirmed by resident reveal that resident A is offered in excess her/his fluid goal each day. Dietary staff report and confirmed through observation that they served resident A one 200ml glass of cold beverage and one 200ml hot beverage each meal plus soup at lunch. Nursing staff report that they offer one 200mls of fluid at snack three times a day. Resident reported and inspector observed nursing to provide additional water at medication pass. At lunch August 7th, 2012 an additional 120ml of water in a Dixie cup was provided to resident. Resident reported that she/he drinks 1 cup of coffee Monday, Wednesday and Friday outside of the home which the homes' interdisciplinary team is unaware of. An interview with a personal support worker who has provided care to Resident A revealed she was not aware of resident A's fluid goal. Interview with resident revealed that she/he was not aware of how much fluid she/he should drink and when but was aware she/he had a fluid goal .[s.6.(7)]
2. The Licensee did not ensure that when care set out in the plan has not been effective that different approaches have been considered in the revision of the plan of care.
Resident C's plan of care was not revised with different approaches being considered when the care set out in the plan related to poor fluid intake was not effective.
Resident C at high nutritional risk was assessed July 5th, 2012 by the previous Registered Dietitian. Documentation stated that resident's "current fluid intake is poor i.e. 310-1034ml/day. Estimated minimum fluid needs are 1100-1320mls/day (25-30ml/kg) do not meet requirements. Resident is being monitored for signs and symptoms of dehydration. Resident is constipated."
The previous RD's plan following the July 5th 2012 assessment was to continue with current care plan. The resident's plan of care was not revised with different approaches being considered. Interview with Food Service Supervisor (FSS) revealed that the nurse manager and FSS "can't think of anything else to do". An interview with the RD revealed that fluid alternatives should have been considered.[s.6.(11)(b)]
3. The Licensee did not ensure that care set out in resident B's plan of care was provided to resident's as specified in her/his plan. Resident B's plan of care requires "high acidic foods be deleted from her diet" requiring a "low acid diet". Resident B received orange juice at breakfast August 3rd, 2012; An interview with the RD revealed this identified resident should not receive orange juice. Resident B's plan of care requires meals to be served on a bright coloured plate to allow the items to be easier to see. At breakfast August 3rd, 2012 her/his meal was served on a white porcelain plate. Staff interview confirmed that orange juice and a white plate did not follow resident B's plan of care. Resident B's plan of care requires the resident to be served an extra 250mls of fluid of choice at meals. Lunch observations August 2nd and 7th and breakfast observation August 7th, 2012 revealed that an extra 250mls fluid of choice was not provided. [s.6.(7)]
4. The Licensee did not ensure that care set out in resident C's plan of care was provided to resident's as specified in her/his plan.
Resident C's plan of care requires her/his to be provided with nectar thick fluids. On August 3rd, 2012 staff passing morning snack stated to inspector and FSS that they did not thicken the boost supplement provided to Resident C. The Food Services Supervisor stated that the boost supplement should have been thickened.
Staff passing morning snack stated an additional drink was not offered to resident C. The Food Services Supervisor stated that a thickened drink in addition to the supplement should have been offered.[s.6.(7)]
5. Resident C at high nutritional risk related to poor food and fluid intake was assessed July 5th, 2012 by the RD. The interventions reassessed included 60mls resource diabetic TID. Staff interviews and medication administration records reveal that resident C has been provided 60mls resource BID and not 60mls resource diabetic TID according to her/his plan of care.
Resident C's plan of care requires staff to provide room temperature fluids when appropriate due to tooth sensitivity. Fluids served at lunch August 2nd, 3rd, and 6th, 2012 were cold and not room temperature. Resident continues to have poor fluid intake.[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 to ensure that nutrition care set out in resident A, B and C's plan of care is provided to the residents' as specified in their plan and the plan of care for resident C is revised with different approaches being considered., to be implemented voluntarily.

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 subsections:

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).

Findings/Faits saillants :

1. The home's nutrition and hydration program does not include a system to evaluate fluid intake of resident's with identified risks.
Resident A at high nutritional risk and requires a specific daily fluid goal.
Residents' fluid intake at meals and snacks is recorded in point click care's point of care (POC) by food service and personal support workers. Registered staff document medication cart water and resource 2.0plus on a separate "Miscellaneous Fluid intake" Sheet. Both sources of fluid, for a combined total, were not evaluated when the registered dietitian (RD) completed her assessment July 29th, 2012 with no concerns identified. Resident A revealed when interviewed that she/he regularly consumes additional fluids off site that is not included in her/his total fluid intake monitored in the home. This resident also stated that she/he was not aware of the her/his required fluid goal.

According to resident A's health record her/his fluid intake exceeded her/his fluid goal on the following dates in July 2012; July 6th- 1725mls, July 11th, -1640mls, July 17th, -1875mls, July 22nd- 1540mls. RD interview revealed that she was not awareness of all recorded fluid sources and did not evaluate resident A's total fluid intake.

An interview with the Nurse Manager revealed the registered staff are directed to combine sources of resident's fluid intake on the "charge Nurse fluid sheet. Registered staff are then expected to identify if resident A is over her/his fluid goal and document a "nursing note to crack down on fluids the next day and further restrict". The Nurse Manager confirmed that registered staff did not evaluate resident A's fluid intake as required when she/he exceeded her/his fluid goal.

The home's policies "Fluid Balance and Fluid intake" Section 4.9 Feeding and Hydration and Nova "Nutritional Care Hydration" index I.D. DS C-05-75 provided to inspector by the Director of Care does not direct staff to evaluate fluid intake.
The policy does not include direction to document and evaluate medication cart water on the "Miscellaneous Fluids Intake" sheets. The policy does not direct registered staff to take action when a resident exceeds his fluid restriction

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 homes' Nutrition Care and Hydration Program includes a system to evaluate the fluid intake of resident's with identified risks related to hydration., 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 subsections:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The Licensee did not ensure that an individualized menu is developed for residents when their needs cannot be met through the home's menu cycle.
Resident A is at high nutritional risk did not have an individualized menu developed to meet her/his nutritional needs and fluid goal.
Resident A's plan of care states her/his estimated nutritional requirements are 2100 cal, 84g protein and 1000-1500ml/day.
Resident A's has been prescribed a specific menu. The Food Service Supervisor and RD defined this menu as 1700-1900 calories and 60-70 g protein each day with sodium, potassium and phosphorus restrictions. Dietary staff report that resident A can eat what she/he wants and makes her/his own choices they restrict only her/his fluids. Resident A reports that she/he does not understand her/his dietary restrictions and expects that staff provide what is appropriate for her/him to eat. The RD revealed when interviewed that the menu plan does not meet resident A's nutritional needs identified in the plan of care.
Interviews with staff and confirmed by resident A reveal that this resident is offered fluids in excess of her/his goal each day. Dietary staff report and confirmed through observation that they served resident A one 200ml glass of cold beverage and one 200ml hot beverage each meal plus soup at lunch. Nursing staff report that they offer one 200mls of fluid at snack three times a day. Resident reported and inspector observed nursing to provide additional water at medication pass. At lunch August 7th, 2012 an additional 120ml of water in a Dixie cup was provided to resident A. Resident A reported that she/he drinks 1 cup of coffee Monday, Wednesday and Friday outside of the home which is not reported to staff in the home. An interview with a personal support worker revealed that she was not aware of resident A's fluid goal. Interview with resident revealed that she/he was not aware of how much fluid she/he should drink but was aware she/he was had a fluid goal.
2. Resident B's plan of care states resident is at moderate risk related to decreased appetite. Resident B's plan of care states resident is to be provided with a "low acid low caffeine diet" due to diagnosis. An individualized menu plan is not in place to address this resident's dietary need. Staff report that they have a list of acidic foods to avoid. Resident was served orange juice at breakfast on August 3rd, 2012. An interview with the RD revealed that resident B should not receive orange juice and that clear direction has not been provided to serving staff.

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 an individualized menu is developed for residents when their needs cannot be met through the home's menu cycle., to be implemented voluntarily.

**THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:**

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CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 6.	CO #002	2012_109153_0001	110
O.Reg 79/10 r. 68.	CO #001	2012_109153_0001	110

Issued on this 12th day of September, 2012

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

Rene Brown