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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 4, 2013	2013_191107_0002	H-002019-12	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

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

DOUGLAS H. RAPELJE LODGE
277 PLYMOUTH ROAD, WELLAND, ON, L3B-6E3

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

MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 22, 23, February 12, 2013

During the course of the inspection, the inspector(s) spoke with Residents in multiple home areas, The Administrator, Food Services Supervisor, Food Services Manager, Registered Dietitian, front line nursing and dietary staff, and Registered nursing staff

During the course of the inspection, the inspector(s) Observed the lunch and dinner meal service; observed food production; reviewed relevant policies and procedures; and reviewed the clinical health record for an identified resident

The following Inspection Protocols were used during this inspection:
Food Quality

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(1)(c)]
The plan of care for resident #001 did not provide clear direction for staff and others who provided direct care to the resident in relation to the dehydration assessments. The plan of care directed staff to complete a weekly hydration assessment, however, the plan did not provide direction for staff on how to complete the assessment. Staff completing the assessments were not all using the same criteria to assess the resident (e.g. various combination of skin turgor, mucous membranes, skin and lip condition, voiding, eye colour, etc), were not consistently using the same language to describe each of the indicators (e.g. fair skin turgor, skin turgor 3+, less than 5 second skin turgor, etc.), and were not consistently taking the same action for similar assessments (e.g. monitor versus encourage fluids). [s. 6. (1) (c)]

2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The care set out in the plan of care for resident #001 was not provided to the resident as specified in the plan. The resident's plan of care directed staff to provide a special item for the lunch and supper meals for the management of poor hydration. The Registered Dietitian confirmed that the menu item was currently required and had not been discontinued. The resident did not receive the menu item at the observed lunch meal February 12, 2013. The Food Services Supervisor confirmed the item was never added to the computer system (for over 1 year) and the resident was not receiving this item at meals, despite being identified on the resident's plan of care. [s. 6. (7)]

3. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)]
a) Resident #001 was not re-assessed and the plan of care reviewed and revised when the resident's care needs changed in relation to diet texture. The resident's Power of Attorney (POA) identified concerns with the resident's diet texture at a team conference and again two months later(identified in the progress notes). A Dietitian referral, to communicate the concerns about the diet texture, was not initiated after the first concerns were identified, resulting in no assessment or change to the resident's plan of care at that time. A Dietitian referral was initiated after the second concern two months later, however, the resident was not assessed by the Registered Dietitian in relation to diet texture for another two months (4 months from when the original concerns were identified).
b) The resident had an identified target weight range, however, the resident's weight was consistently between below the target for two years. Strategies were not in place for weight gain and the Dietitian confirmed the goal was for weight maintenance and not weight gain. The target weight range was not re-assessed and revised in relation

to current goals for the resident.
c) The plan of care was not revised in relation to nutritional strategies for the prevention of constipation. The resident had an increase in the amount of constipation, requiring a number of as needed laxatives over a five month period. A constipation 'Resident Assessment Protocol' (RAP) identified that prunes would be offered to the resident every morning to try to increase bowel function. The plan of care was not revised to include this information. [s. 6. (10) (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 the home complies with s.6(1)(c), s.6 (7), and s.6(10)(b), to be implemented voluntarily.

WN #2: 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. [O.Reg. 79/10, s. 8(1)(a)]
The licensee of the home did not ensure that their policy, "Criteria for Referral to Registered Dietitian C030406", was in compliance with all applicable requirements under the Act. The Long Term Care Homes Act, O.Reg. 79/10, s. 50(2)(b)(iii), requires that "a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home." The licensee's policy identified that only venous or arterial wounds and stage 3 or higher skin breakdown was required to be referred to the Registered Dietitian, which was not consistent with the requirement under the Act.

[O.Reg. 79/10, s. 8(1)(b)]
The licensee did not ensure that the "Food and Fluid Intake RC 110401" policy was followed by staff providing care to resident #001. The policy identified signs and symptoms of dehydration as: dry mucous membranes, decreased skin turgor, skin breakdown, rapid weight loss in less than a week, rapid pulse, weakness, decrease in orthostatic blood pressure, decreased urine output, changes in mental status, and constipation. The policy identified that the day shift Registered Nurse/Registered Practical Nurse (RN/RPN) would assess the resident for signs and symptoms of dehydration and document findings in the resident's chart. The Registered staff would make a referral to the Registered Deititian and the physician or Nurse Practitioner to consider other interventions, and the day shift RN/RPN would review the assessment findings with the resident or their substitute decision maker (SDM) and discussion would include next steps, care plan options and agreement with interventions.
The policy was not followed by staff when signs and symptoms of dehydration were identified in resident #001's weekly dehydration assessments. A referral to the Physician and Registered Dietitian did not occur and discussion with the resident's SDM in relation to next steps did not occur when symptoms of dehydration were identified.
The weekly dehydration assessments were reviewed over a 5.5 month period. Action was not taken by staff when the results of the dehydration assessments indicated that the plan was not effective to maintain the resident's hydration level.
i) Decreased skin turgor was identified on 22 of the assessments.
ii) Dry mucous membranes were identified on 10 of the assessments.
iii) A urinary tract infection was identified by staff in the progress notes.
iv) Staff identified the resident had a change in skin integrity with potential for skin breakdown during this period.
v) Behavioural issues and/or some confusion were noted on five occasions. The

behavioural symptoms corresponded with dates of identified dry oral mucosa and decreased skin turgor on all noted dates except one.
vi) A low blood pressure alert was identified in the progress notes.
vii) Ongoing constipation (increased amount over a two month span).
Action taken by staff was to encourage fluids or to continue to monitor. The home's policy was not followed with action taken when poor hydration was identified through the dehydration assessments. [s. 8. (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 with s. 8(1)(a) and s. 8(1)(b), to be implemented voluntarily.

WN #3: 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,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 72(2)(d)]
Not all menu items were prepared according to the planned menu.
Staff preparing and serving the pureed pasta and meat sauce at the supper meal January 22, 2013, did not follow the planned menu resulting in reduced nutritive value of the meal. The planned menu instructed staff to use a #8 scoop of the pureed pasta and a #6 scoop of the pureed meat sauce. Staff preparing the meal mixed the meat and pasta together in the same pan and staff portioning provided only a #6 scoop of the combined product, resulting in a smaller portion being served to residents. [s. 72. (2) (d)]

2. [O.Reg. 72(3)(a)]
Not all food was prepared, stored, and served using methods that preserved taste, nutritive value, appearance and food quality. Ten of 14 residents interviewed voiced concerns about food quality.
a) Chicken fingers for the texture modified menus (minced and pureed), and perogies for all textures were cooked the day prior, cooled, then placed into the oven prior to 1420 for reheating for the supper meal at 1700 on January 23, 2013. This method did not preserve nutritive value (food is exposed to heat twice and for an extended period of time), and food quality (food became dry). The recipe for the chicken fingers stated to cook for up to 19 minutes.
b) The pork served at the supper meal January 22, 2013 was quite dry when tasted by the inspector. One resident sent their meal back stating their meat was dried out.
c) The pureed pasta served at the supper meal January 22, 2013 was dried out and had a hard coating on the top that was then mixed into the rest of the pan of pasta. The hard coating was difficult to eat and may pose a choking risk for some residents with difficulty swallowing.
d) The pan of broccoli served at the supper meal January 22, 2013 contained only 2 florets and the rest were stems. One resident sent their meal back and complained that the broccoli was mostly stems which were woody and they could not eat them. [s. 72. (3) (a)]

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 s. 72(2)(d) and s. 72(3)(a), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 30(2)]
The licensee did not ensure that actions taken with respect to resident #001 under the dietary services and hydration program were documented. A "Feeding Swallowing Screen" three meal assessment was initiated, however, the documentation was incomplete. [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (2) The licensee shall ensure that each menu,
(b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 71(2)(b)]
The menu did not provide a variety of foods and multiple foods were repeated throughout the 3 week menu cycle, served on consecutive days, on the same day of the week on multiple weeks, and similar foods were served multiple times within the week or within the same meal. During interview, 7/13 residents identified that the menu was repetitious. The Food Committee Meeting minutes for December 2012 identified that jello was on the menu frequently, and concerns about too much jello were voiced during interview.
Some examples:
Week 1 - salad type sandwiches Sunday lunch (side dish with mayonnaise also), Monday lunch, Wednesday lunch; open faced sandwich Tuesday lunch and Thursday lunch; jello Tuesday lunch, Thursday supper, Saturday supper; peaches Friday lunch and Fruit cocktail (with peaches) Saturday lunch
Week 2 - Thursday supper both entrees are beef (no choice if resident does not consume beef); Thursday supper meatloaf and Friday supper meatballs (both ground beef); Tuesday lunch jello (also served Tuesday Week 1 lunch) and again Thursday lunch (also served Thursday week 1); yogurt served Tuesday supper and Saturday supper; Wednesday lunch tapioca pudding (served Wednesday week 1); Saturday had an unusual combination of foods - pizza served with green beans and Monday lunch has hamburger with squash
Week 3 - jello on Sunday lunch, Wednesday lunch and Friday lunch
Multiple menu items are repeated within the 3 week cycle, however, documentation does not support that this was due to resident preference. [s. 71. (2) (b)]

Issued on this 4th day of March, 2013

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

M. Warrener, RD