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
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 21, 24, 25, 26, 27, 2012	2012_038197_0025	Complaint

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North, OSHAWA, ON, L1J-4L1

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

EXTENDICARE KINGSTON
309 QUEEN MARY ROAD, KINGSTON, ON, K7M-6P4

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Registered Dietitian, the Nutrition Manager, the Environmental Manager, reception staff, a Registered Nurse, Registered Practical Nurses, Personal Support Workers and a resident.

During the course of the inspection, the inspector(s) reviewed policies related to weight loss and food and fluid documentation, resident daily food and fluid intake sheets, home census reports, Registered Dietitian hours, a weights and vitals exception report, medication administration records, health care records and observed a resident and a resident's room.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Nutrition and Hydration

Personal Support Services

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 6(7) in that the care set out in the plan of care was not provided to a resident as specified in the plan.
Resident # 1's plan of care dated September 2012 states that the resident is to receive a nutritional intervention at AM and HS snack since the resident is underweight.
On September 24, 2012 it was observed that the resident received a nutritional intervention at PM snack.
The Registered Dietitian checked with the dietary staff on September 25, 2012 and confirmed that the resident was receiving a nutritional intervention at PM snack and not at AM snack.
2. The licensee has failed to comply with LTCHA 2007, s. 6(8) in that staff who provide direct care to a resident were not kept aware of the contents of the plan of care.
Resident # 1's plan of care dated September 2012 was reviewed. A nutritional intervention is listed on the plan of care for this resident to be given AM and HS snack since the resident is noted to be underweight.
On September 24, 2012 it was observed that the resident received a their nutritional intervention at PM snack.
During an interview with the Registered Dietitian on September 25, 2012, she stated that the resident previously received a nutritional intervention at PM and HS snacks, but this was changed to better suit the resident's needs.
During an interview with staff member # S100 who indicated that she is full-time and often provides care to this resident, she stated that the resident receives a nutritional intervention at PM and HS snack.
Direct care staff were not made aware of the changes to the resident's plan of care.

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 care set out in the plan of care is provided to residents as specified in the plan and that there is a process in place to ensure that staff who provide direct care to residents are kept aware of any changes made to the plan of care, 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 8(1)(b) in that they did not comply with their system required under O. Reg. 79/10, s. 68(2)(d) to monitor food and fluid intake of all residents with identified risks related to nutrition and hydration.
During an interview with the Director of Care on September 24, 2012, she stated that food and fluid is documented by Personal Support Workers (PSW's) on the Resident Daily Food and Fluid Intake sheets on each unit and that nursing staff document all nutritional supplements on the Medication Administration Record (MAR). She further stated that back slashes and blank spaces should not be documented on the food and fluid intake sheets and that if residents do not attend a meal for any reason there should be a note made with an explanation.

Resident # 1 is noted to be at moderate nutritional risk due to being underweight. The resident receives a nutritional supplement two times daily and his/her plan of care specifically states that staff will monitor the amount of food and fluids at meals and snacks and document in the food and fluid intake binder.

Resident # 2 is noted to be at high nutritional risk due to being severely underweight and having other contributing medical diagnoses. He/she receives a nutritional supplement four times daily and the plan of care for this resident specifically states that staff will document on food and fluid sheets the amount of food and fluid taken daily.

Resident # 3 is noted to be at high nutritional risk due to being severely underweight and receives a nutritional supplement with meals.

The Resident Daily Food and Fluid Intake sheets for the months of July, August and September 2012 were reviewed for residents # 1, # 2 and # 3.

For September 2012 the following was found as of September 25, 2012:
Resident # 1 - five doses of a nutritional supplement were not signed for on the medication administration record and 9 breakfast, 2 lunch and 3 dinner food and fluid intakes were not documented according to the home's procedure for documenting food and fluid intakes.

Resident # 2 - 22 breakfast, 13 lunch and 8 dinner food and fluid intakes were not documented according to the home's procedure for documenting food and fluid intakes.

Resident # 3 - 21 doses of a nutritional supplement were not signed for on the medication administration record and 9 breakfast, 2 lunch and 3 dinner food and fluid intakes were not documented according to the home's procedure for documenting food and fluid intakes.

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 system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration is complied with, to be implemented voluntarily.

WN #3: 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 has failed to comply with O. Reg. 79/10, s. 69 in that significant weight changes were not assessed using an interdisciplinary approach and actions were not taken and outcomes were not evaluated.
Resident # 1 triggered for a significant weight loss of 10 %, or more, over six months.
When reviewing resident # 1's health care record, there was no evidence of an interdisciplinary assessment related to this significant weight loss, nor was there any documentation related to actions taken or the evaluation of interventions that were in place to help prevent the resident from losing weight.
During an interview with the Registered Dietitian on September 25, 2012, she stated that she documents her assessments in the written progress notes or in the residents quarterly MDS (Minimum Data Set) assessments. She further confirmed that she had not done a formal assessment of the resident related to weight loss and stated that she should have made a note in the progress notes but did not.
Resident # 2 triggered for a significant weight loss of 5 per cent of body weight, or more, over one month.
Upon review of resident # 2's health care record there was no evidence of an interdisciplinary assessment related to the resident's weight loss or actions taken or the evaluation of current interventions in place to help prevent weight loss.
During an interview with the Registered Dietitian on September 25, 2012 she stated that she had not formally assessed the resident in relation to the significant weight loss. She did state that when she was assessing another resident she noticed that resident # 2 was not doing well and did review his/her health care record the during the week of September 17, 2012. However, she stated she did not make any notes in the resident's health care record at this time.
The Registered Dietitian came back at a later time and indicated to the inspector that she felt there had been a weight error for resident # 2 which may have falsely triggered the significant weight loss. She stated that she should have requested a re-weigh, but did not.

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 significant weight changes are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following subsections:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 74(2) in that the Registered Dietitian for the home was not on-site for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

Paid Registered Dietitian (RD) hours were reviewed for the months of June, July and August 2012.

According to the home's census report, there were on average 149 residents living in the home for the month of June 2012. In June 2012, the RD worked a total of 62 hours which was short 12.5 hours of the required 74.5 hours of on-site RD time.

According to the home's census report, there were on average 147 residents living in the home for the month of August 2012. In August 2012 the RD worked a total of 50.5 hours, which was short 23 hours of the required 73.5 hours of RD time.

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 for the home is on-site for a minimum of 30 minutes per resident per month to care out clinical and nutrition care duties, to be implemented voluntarily.

Issued on this 27th day of September, 2012

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