Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 26, 2020	2020_661683_0021	013167-20	Complaint

Licensee/Titulaire de permis

Foyer Richelieu Welland
655 Tanguay Ave Welland ON L3B 6A1

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

Foyer Richelieu Welland
655 Tanguay Avenue Welland ON L3B 6A1

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

LISA BOS (683)

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): November 17, 18, 19, 20 and 23, 2020.

The following intake was completed during this complaint inspection:
Log #013167-20 was related to nutrition and hydration, continence care and bowel management and hospitalization and change in condition

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Registered Dietitian (RD), the Nutrition Manager, dietary staff, registered staff, Personal Support Workers (PSWs), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, menus, policies and procedures and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 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	Légende 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. (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. The licensee has failed to ensure that the medical directive was followed for a resident, as per their plan of care.

A complaint was received related to the home not treating symptoms of an infection in a resident.

The home's medical directive stated that if a resident demonstrated symptoms of an infection, an intervention was to be implemented for 24 hours and if the resident's symptoms continued, a specimen was to be collected. Staff were to notify the physician if the resident was symptomatic and when the lab results were received.

A) A review of a resident's clinical record identified that there was a decline in their health status and a Registered Practical Nurse (RPN) documented that they may need to rule out an infection. Several days later, the resident reported symptoms of an infection and staff documented that they agreed to a procedure. The resident continued to have a decline in their health condition and an RPN documented that they would try to do a procedure. Several days later, the physician was contacted regarding the decline in the resident's health status and a test was ordered. The next day, the resident's condition continued to decline, and they were transferred to hospital where they were diagnosed with an infection.

There was no documentation in the resident's clinical record that a specimen was collected as per the home's medical directive, which put the resident at risk of complications associated with an undiagnosed infection.

B) A review of a resident's clinical record identified that they complained of symptoms of an infection. The next day, the resident continued to complain of symptoms of an infection and several days later, the resident's Power of Attorney (POA) reported that their symptoms continued. 10 days later, the resident continued to report symptoms of infection. A specimen was not collected until 16 days after symptom onset, and when the sample came back, the resident was diagnosed and treated for an infection.

A specimen was not collected as per the home's medical directive until 16 days after symptom onset, which put the resident at risk of complications associated with an undiagnosed infection.

In an interview with a Registered Nurse (RN), they indicated that the home's process was for staff to implement an intervention after symptom onset, and if the symptoms did not resolve within 24 hours, a specimen would be collected. If their symptoms resolved, staff should document that. They reviewed the resident's clinical record and acknowledged that there were no specimens collected when the resident demonstrated symptoms of infection in part A, and acknowledged that a specimen was not collected until 16 days after symptom onset in part B, despite documentation of continued symptoms.

Sources: A resident's clinical record, the home's medical directive and interview with a RN. [s. 6. (7)]

2. The licensee has failed to ensure that a resident's plan of care was revised when their nutrition risk changed.

A review of a resident's quarterly nutritional assessments and nutrition risk assessments identified that they were at a specific nutritional risk. A review of their written plan of care in place at the time of the inspection identified a different nutrition risk level. In interviews with the Nutrition Manager and Registered Dietitian (RD), they acknowledged that the resident's nutrition risk changed and their written plan of care should have been updated to reflect the change.

Sources: A resident's clinical record, interview with the Nutrition Manager, RD and other staff. [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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that seven-day and daily menus were communicated to residents.

Upon observation of the lunch meal service, the Inspector noted that the daily and weekly menus were not posted outside either of the home's two dining areas. In an interview with the Nutrition Manager, they acknowledged that the menus were not posted for the past few weeks because the home switched to their fall pandemic menu, but acknowledged that the summer pandemic menu was posted previously.

The home did not ensure that the seven-day and daily menus were communicated to residents.

Sources: Mealtime observations, and interview with the Nutrition Manager and other staff. [s. 73. (1) 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 that the home has a dining and snack service that includes communication of the seven-day and daily menus to residents, to be implemented voluntarily.

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 their "Unplanned Weight Loss Procedure" included in the required dietary services program was complied with, for two residents.

LTCHA s. 11 (1) (b) requires an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

O. Reg. 79/10, s. 68 (1) (a) and O. Reg. 79/10, s. 68 (2) (e) (i) requires the program to include a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

Specifically, staff did not comply with the home's "Unplanned Weight Loss Procedure," which required all resident's weights to be taken and monitored monthly.

A) A review of the clinical record for a resident did not identify a weight for a specific month, nor was there documentation that the resident was out of the home or refused their weight to be taken. In an interview with the Nutrition Manager, they acknowledged that upon their review of the resident's clinical record, there was no documented weight for that month, as per their "Unplanned Weight Loss Procedure."

Sources: A resident’s clinical record and interview with the Nutrition Manager.

B) A resident’s clinical record was reviewed and there was no documented weight for a specific month, nor was there documentation that the resident was out of the home or refused their weight to be taken. In an interview with the Nutrition Manager, they acknowledged that upon their review of the resident's clinical record and discussions with nursing staff, there was no documented weight for that month, as per their "Unplanned Weight Loss Procedure."

Sources: A resident’s clinical record and interview with the Nutrition Manager. [s. 8. (1) (a),s. 8. (1) (b)]

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. The licensee has failed to ensure that any assessments completed with respect to a resident under the nutrition care and dietary services program were documented.

LTCHA s. 11 (1) (b) requires an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

O. Reg. 79/10, s. 69 requires residents with the following weight changes to be 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.

i) A resident's clinical record indicated that they experienced a significant weight loss over three months. There was no documentation of an assessment completed for the resident's significant weight loss until the RD completed their quarterly nutrition assessment the following month.

ii) A resident’s clinical record indicated that they experienced a significant weight loss over six months. There was no documentation of an assessment completed for the resident's significant weight loss at the time of the Inspector's record review.

In an interview with the RD, they indicated that residents were usually weighed within the first two weeks of the month, and they started to review residents with a significant weight change around the third week of the month. They indicated that they were aware of the resident's significant weight change and they were actively involved in the resident’s care but acknowledged that they did not document their assessments related to the resident's significant weight change.

Sources: A resident’s clinical record, interview with the Registered Dietitian and other staff. [s. 30. (2)]

Issued on this 2nd day of December, 2020

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

Original report signed by the inspector.