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
Apr 11, 2014	2014_157210_0006	T-736-13	Complaint

Licensee/Titulaire de permis

HELLENIC CARE FOR SENIORS (TORONTO) INC
33 WINONA DRIVE, TORONTO, ON, M6G-3Z7

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

HELLENIC CARE FOR SENIORS (TORONTO) INC.
215 TYRREL AVENUE, TORONTO, ON, M6G-4A9

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

SLAVICA VUCKO (210)

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): March 12, 13, 2014

During the course of the inspection, the inspector(s) spoke with personal support workers (PSW), registered nurse (RN), registered practical nurse (RPN), resident assessment instrument (RAI) coordinator, director of care (DOC), registered dietitian (RD).

During the course of the inspection, the inspector(s) observed the provision of care, reviewed clinical records.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Skin and Wound Care

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Findings of Non-Compliance were found during this inspection.

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	Legendé 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 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 of the home failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A review of the Subcutaneous Infusion of Medications or Parenteral Fluids (Hypodermoclysis)" policy, revised on April 2013, recommends that, to minimize transfers to hospitals for rehydration or pain management, and where registered staff is skilled, Hypodermoclysis, for parenteral fluids and\or medication administration into the subcutaneous tissue, may be utilized.
Interview with identified staff indicated when resident #1 had a decreased or no fluid intake the Hypodermoclysis method for rehydration was not taken into consideration. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care for resident #1 is based on an interdisciplinary assessment of resident's hydration status and any risks related to hydration.

A review of the written plan of care in relation to eating and nutrition for resident #1, at the end of 2013, indicated resident was at high nutritional risk because of chewing and swallowing difficulties, significant weight loss, and other contributing diagnoses. In the period November-December 2013, resident #1 had average daily fluid intake of 400-800 ml/day, that was approximately half of the daily fluid intake, 1750ml/day, recommended by RD. According to progress notes, at the beginning of December, 2013, a referral was sent to RD for resident #1 to be assessed for weight loss of 4kg during one month. Few days later, RD changed resident food texture and increased the daily dose of food supplement. Three days after RD assessment, the resident was assessed by the physician and prescribed an antibiotic. On the same day he\she was sent to hospital for increased heart rate, being lethargic and possible aspiration.
A review of the plan of care does not indicate an interdisciplinary assessment of the resident's hydration status and any risks related to hydration. [s. 26. (3) 14.]

2. The licensee failed to ensure the RD who is a member of the staff of the home assessed the resident's hydration status, and any risks related to hydration when there was a significant change in the resident's health condition.

A review of the food and fluid intake record for resident #1 indicated during one month period in November-December 2013, the resident had an average daily fluid intake 400-800ml, that was approximately half of the daily fluid intake, 1750 ml/day, recommended by the RD. As per the nursing notes at the beginning of December 2013, the resident was lethargic, had increased heart rate, and had decreased appetite.
A review of the clinical record and interview with an identified staff confirmed RD was not notified about the change in the fluid intake in order to complete assessment of the hydration status and risks related to hydration. [s. 26. (4) (a),s. 26. (4) (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 RD who is a member of the staff of the home assessed the resident's hydration status and any risks related to hydration when there is a significant change in the resident's health condition, to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 failed to ensure that staff and others involved in the different aspects

of care collaborate with each other in the assessment of resident #1 so that their assessments are integrated, consistent with and complement each other.

A review of the nursing progress notes and PSWs flow sheets indicated different values for the food intake of resident #1 as follows:
-Nursing notes from different dates in December 2013, stated resident #1 ate mostly 25% of his\her meals, whereas PSWs flow sheets indicated bigger amount of food intake such as 50%,100% or resident refused.

Interview with PSWs and registered staff confirmed that the documentation completed by the PSWs was not accurate in order to assess the daily food intake of a resident. [s. 6. (4) (a)]

2. The licensee failed to ensure the resident' #1' SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care.

A review of the written care plan indicated resident #1 was at high nutritional risk due to significant weight loss, chewing and swallowing difficulties and other contributing diagnoses.
A review of the food and fluid intake record for resident #1 for a period of one month in November and December 2013, indicated the resident had an average daily fluid intake of 400-800ml/day that was less than the daily fluid intake 1750 ml\day recommended by the RD. A review of the food intake record for a certain day in December 2013, indicated resident #1 had 25-50% of the meals most of the time. The following day, resident #1 refused all of the meals, was sent to hospital, was treated with antibiotics, and returned to the home early the following day. After the return from hospital, resident refused all meals, fluids and medications all day and was sent to hospital again the next day.The resident passed away two weeks after the hospitalization. Interview with SDM, review of clinical record and interview with identified staff indicated the SDM was not informed about the significantly decreased food and fluid intake in the period November-December, 2013.

A review of the weight change record indicated resident #1 lost 4 kg during a month period, from November to December, 2013. In December, 2013, the resident was referred to RD for assessment. A review of the clinical records and interview with identified staff indicated the resident's SDM was not notified of the significant weight loss of more than 5% until 5 days later, on the second hospital admission. [s. 6. (5)]

3. A review of the clinical record for resident #1 indicated in December 2013, the RD increased the daily dose of a food supplement, because of the weight loss. A review of the progress notes and interview with identified staff confirmed the food sup;lement is not considered a prescription in order to notify the SDM of the new order. Therefore the resident #1's SDM was not informed about the change in the daily dose of food supplement. [s. 6. (5)]

4. A review of the clinical record indicated on resident #1 was sent to hospital for one day in December 2013, and he\she was treated with antibiotics. The resident returned to the home with a prescription of two antibiotics to be given through mouth. The same day resident #1 slept most of the day and refused to eat or drink all day, therefore did not receive the prescribed dose of antibiotics. Interview with the resident's SDM and review of progress notes indicated on the day when resident returned from hospital SDM was promised to be updated on any resident's health status change.
The SDM was not notified that resident did not eat, drink or taken the antibiotics until the next day, when resident #1's SDM visited the home. The resident was sent to the hospital again. [s. 6. (5)]

5. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs changed.

A review of the written plan of care for resident #1 indicated the resident was at high nutritional risk due to significant weight loss, chewing and swallowing difficulties, and other contributing diagnoses. The goal was to maintain good fluid intake of 1750mls/day, to maintain adequate hydration.
A review of the food and fluid intake record November-December, 2013, for resident #1 indicated the resident had an average daily fluid intake of 400-800ml that was approximately half of the RD recommended daily fluid intake. A review of the food intake record and nursing notes indicated at the beginning of December 2013, the resident had 25-50% food intake most of the time. Progress notes from the same period indicated resident #1 was lethargic. Interview with identified staff confirmed that when there is a change in the health status of a resident the daily food, fluid and snack intake has to be reviewed, in order further action to be taken.

Interview with identified staff indicated the food and fluid intake has to be evaluated in the electronic documentation chart. Interview with another identified staff confirmed when resident #1's care needs changed staff did not review the daily food, fluid and

snack intakes. [s. 6. (10) (b)]

Issued on this 14th day of April, 2014

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

SLAVICA VUCKO