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
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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
May 30, Jun 5, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28, Jul 13, Aug 22, 30, 2012	2012_065169_0010	Resident Quality Inspection

Licensee/Titulaire de permis

IDLEWYLD MANOR
449 SANATORIUM ROAD, HAMILTON, ON, L9C-2A7

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

IDLEWYLD MANOR
449 SANATORIUM ROAD, HAMILTON, ON, L9C-2A7

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

YVONNE WALTON (169), MARILYN TONE (167), TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing, Manager of Resident Services, Food Service Manager, Manager of Recreation services, Dietitian, Education consultant, residents, families, dietary and nursing staff, President of the Resident's Council and Family Council Members.

During the course of the inspection, the inspector(s) conducted clinical health reviews, observed care and services and reviewed policies and procedures.

This Resident Quality Inspection references Log# H-00993-12. An environmental inspection occurred concurrently with this Resident Quality Inspection. Please reference Inspection#2012_072120_0049 and Log# H-001104-12.

Included in this Resident Quality Inspection #000993-12 report are concurrent inspections:
Critical Incidents H-00813-12, H-00631-12
Complaints H-001638-11 (refer H-00773-12), H-001791-11, H-001661-11, H-00130-12, H-00688-12
Other (inspector initiated) H-00866-12

The following Inspection Protocols were used during this inspection:

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

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.) 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. (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;
(b) the goals the care is intended to achieve; and
(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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. S.6(1)(c) The licensee of the long term care home did not ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

a) Resident #890 was initially receiving a nutritional supplement three times per day and the home's dietitian increased the resident's volume and frequency of supplement. The resident's medication administration record indicated the initial supplement was discontinued however, the resident continued to receive both supplements. The dietitian confirmed that the expectation was that the initial supplement (three times a day) was discontinued. The interventions on the resident's plan of care only indicated that the resident was receiving the initial nutritional supplement.
b)The licensee did not ensure the plan of care for resident # 890 set out clear direction to staff and others who provide direct care to the resident.

i) Resident # 890 was deemed by the physician to have a change in health status. The document that the home refers to as the care plan was noted to be updated to include the resident's change in health status except for nutritional intake where conflicting data was present.

ii)Resident #890's plan of care stated the resident was not able to eat or drink, however the plan of care identified specific interventions related to nutritional intake, hence conflicting.
The eating care plan indicated that the resident was to eat meals in the dining room, however other information on the resident's care plan indicated that the resident was no longer able to do so related to the change in health status.

iii) Resident #890 was noted in the care plan to be bedridden. There was documentation on the care plan in another area to indicate that staff should take extra care when transferring and ensure safety around sharp objects ie. toilet paper holders, wheelchair pedals etc.

iv) The care plan related to mobility for resident #890 indicated that the resident is bedridden but also indicates that the resident would receive exercises three times per week if the resident agrees.

2. S.6(10)(b) The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan was no longer necessary.

i) Documentation in Resident #890's clinical record indicated the resident's recreation and social needs changed however; the resident was not reassessed and their recreation plan of care reviewed and revised to reflect the resident's care needs. The interim recreation manager confirmed that the expectation was that a plan of care be developed to address the change in resident's care needs.

ii)The plan of care for Resident #876 indicated the resident was bed ridden however, their plan of care was not revised when interventions set out in their plan were no longer necessary.
The care plan indicated that the resident was at high risk for skin breakdown but did not indicate the actual skin requirements.

iii)Resident #909 was observed in bed with one full bedrail up while in bed during the day. The plan of care identified the use of both rails while in bed at night. The physician discontinued the use of bedrails as the resident no longer needs them. The progress noted identify there is no restraint required or used by the resident. The Registered Practical Nurse confirmed the resident uses 2 bedrails at night.

iii) Resident # 895 required a treatment intervention. The resident has required a treatment including dressing changes to an area and these were not reflected in the plan of care.
The document that the home refers to as the care plan that is currently in the care plan binder and was confirmed to be the most current care plan was not reviewed and revised to include any mention of the interventions in place.

3. S.6(7) The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

i) Resident #862 did not receive care as specified in the plan of care. The progress notes identify the resident had an unwitnessed fall, and the progress notes identify the resident had a witnessed fall. The plan of care identified the resident was to receive specific interventions for falls prevention, however these were not provided and the resident sustained a fall with an injury.

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 that ensures there is a written plan of care for each resident that sets out, the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident. Also 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 the resident's care needs change or care set out in the plan is no longer necessary or care set out in the plan has not been effective., 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. 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 was complied with.
The home's weight monitoring program policy (RC-03-01-08) indicated that nursing staff weigh residents on their first bath day of the month with all weights completed by the 7th of the month. Significant discrepancies of 2.2kg will have a reweigh taken and recorded in point click care by the 10th of the month. However, the home did not always take and record monthly weight and reweighs in point click care as specified in their policy. At least fifteen residents did not have their monthly weights taken and recorded in point click care by the 15th of the month. Resident #876 did not have a monthly weight recorded in point click care for one month and did not have a re-weigh recorded in point click care on five occasions . Resident #890 did not have a re-weigh taken and recorded in point click care for one month.

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 that ensures the licensee 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 is complied with., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has not ensured that residents who are admitted to the home are screened for tuberculosis within 14 days of admission.
The clinical records indicated resident #10 received tuberculosis screening 25 days after admission, resident #11 received tuberculosis screening 19 days after admission, resident #13 received tuberculosis screening 22 days after admission and resident #14 received tuberculosis screening 34 days after admission.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

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.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure the home has a dining and snack service that includes, at a minimum a review, subject to compliance with subsection 71(6), of meal and snack times by Residents' Council.
The Residents' Council minutes were reviewed for the past 12 months and there was no evidence the licensee has reviewed the meal and snack times with the Residents' Council.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. 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
(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. S.26(4)(a) The licensee did not ensure that a registered dietitian who was a member of the staff of the home, completed a nutritional assessment for all residents on admission and whenever there was a significant change in a resident's health condition.
Resident 890 returned from hospital and documentation in the resident's clinical health record indicated that the resident continued to loose weight/unstable, appetite was very poor, refused to eat majority of the time and refused fluids however, the home's dietitian confirmed that there was no referral sent to the dietitian related to the resident's significant change in health condition and no assessment completed upon their return from hospital.
2. S.26(3)18 The licensee did not ensure that the plan of care for resident # 26 was based on an interdisciplinary assessment with respect to the resident's special treatments and interventions.

a) It was noted during an interview with the resident that they were receiving a treatment from an outside agency. The agency did not document in the resident's health record and has not provided any information to support an assessment of the resident's status.
b) A review of the document that the home refers to as the care plan and the treatment administration records for the resident revealed that there is no mention of any interventions or treatments for the resident's condition.
c) A review of the health file for the resident revealed that there was no assessment or evaluation of the resident's condition.
d) An interview with a registered staff member confirmed that she had no knowledge of a treatment being provided to the resident. The registered staff member interviewed confirmed that the treatment was not found in the resident's care plan or on the treatment administration records.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

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. S.30(2) The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

a) Resident #876 plan of care indicated the resident was to be offered supplementation twice a day however, there was no documentation in the resident's clinical record (point of care) on twenty- five occasions over a month, with respect to the resident's acceptance of the intervention.
b) A review of the bowel flow sheet for Resident #929 completed by the Personal Support Workers, for the period of 15 days identified 3 signatures were missing during the month, another month indicated 4 signatures were missing. This was confirmed by the Personal Support Workers and the DOC.
c) Resident # 26 receives treatment by an outside agency.
There was no documentation on the resident's health file to indicate that this treatment was taking place nor was there documentation to indicate that assessment, reassessment or the resident's response to the intervention has been occurring.
d) The physician's order for resident # 895 directed staff to provide a treatment to the resident twice daily. It was noted during a review of the Treatment Administration Record (TAR) for the resident that during a month, the treatment was done daily, instead of twice daily, and not documented as provided 18 out of 60 times that month.
- During another month, the TAR indicated that the treatment was not provided 16 times that month.
- A review of the TAR for another month indicated that the treatment was not documented as provided 9 out of 60 times as ordered.
The registered staff member confirmed that the treatment was provided to the resident as ordered.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that Resident #890 received a skin assessment by a member of the registered nursing staff upon return from hospital.
Resident #890 returned from hospital. The post hospital assessment completed in the progress notes by registered nursing staff identified that the resident had a skin issue. There was no mention of the skin issue in the progress notes but did mention the resident had two other skin issues and would be referred to the wound care specialist. The Enterostomal Nurse (wound care specialist) assessed the resident's skin care issues. Enterostomal Nurse indicated the resident's skin care issue as an ongoing issue, however the nursing staff did not assess one of the skin issues.
The registered nursing staff at the home did not complete a full assessment of resident #890's skin upon their return from hospital.

WN #8: 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. S.69 The licensee of the long term care home did not ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions 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.

a)Resident #876 did not have action taken and outcomes evaluated when they had significant weight loss of 15.5% The resident had a 7.2% weight loss over one month and their weight was not assessed until 2 months later however; actions were not taken and outcomes were not evaluated despite continued weight decline. The resident triggered a significant weight loss over 6 months however; action was not taken and outcomes were not evaluated.

b)Resident #972 experienced a significant weight loss of 6% over one month and a significant weight loss of 8.4% over three months however the home's dietitian confirmed that there was no referral related to the resident's weight changes and there was no assessment using an interdisciplinary approach, actions taken and outcomes evaluated despite the resident's changes in weight.

WN #9: 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. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration;
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner;
(d) includes alternative beverage choices at meals and snacks;
(e) is approved by a registered dietitian who is a member of the staff of the home;
(f) is reviewed by the Residents' Council for the home; and
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. S. 71(1)(e) The licensee of a long term care home did not ensure that the home's menu cycle, was approved by a registered dietitian who was a member of the staff of the home. The home's dietitian confirmed June 20, 2012 that she had reviewed and provided feedback to the licensee, however had not approved the home's menu cycle at the time of the inspection.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

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
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. (Please Note: This evidence of non compliance was found during inspection # 2012_065196_0008 Log#H-00688012)

The licensee of a long term care home did not ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality.
a)Puree textured menu items (Italian mixed vegetables, cauliflower and beef) prepared June 18 and June 20, 2012 for the supper and lunch meals were runny.
b) On June 18, 2012 prior to the supper meal a family member expressed concerns regarding the consistency of pureed textures served.
c) On June 20, 2012 the dietary staff at the lunch meal had to return the puree cauliflower and beef to the main kitchen as the consistency was too runny.
d)Dietary staff confirmed that recipes for puree menu items were not used and that some recipes did not reflect actual practice of staff preparing the meals.
e)Portion sizes used to serve puree pork (#6), minced pork (#10) and potato salad (#8) for the dinner meal June 18, 2012 did not reflect the portion sizes indicated on the homes therapeutic menu.
f)The therapeutic menu did not always correspond with the production menu. For example, the production sheet for supper June 18, 2012 indicated to use #20 scoop for pureed pork on a bun and two #16 scoops for puree bread however, the therapeutic menu indicated to use #6 scoop. Mashed potatoes were on the planned menu for Tues lunch week 1 however they were not listed on the production sheet for staff to prepare.
g)The food service supervisor confirmed that quantities on the production sheet do not always reflect yields indicated on the recipes.
h)Dietary staff confirmed that they ran short of puree pork during the supper meal June 18, 2012 for at least three residents in Creekside home area.

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 that ensures that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value,appearance and food quality, to be implemented voluntarily.

WN #11: 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. S.68(2)(a) The licensee of the long term care home did not ensure that the programs include the development and implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration. The home did not have a policy and procedure related to food temperatures in the food services manual and the food service supervisor and the home's dietitian confirmed that the home did not have a food temperature policy fully implemented at the time of the inspection. The dietitian confirmed that many of the policies and procedures related to nutrition care and dietary services and hydration were out dated and that the development and implementation of current policies to reflect the home's current practices in nutrition care and dietary services and hydration was not completed at the time of the inspection.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following subsections:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3);
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. S.85(4)(a) The licensee does not document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey. This was confirmed by the President of the Residents' Council and the minutes of the meetings.
2. S.85(3) The licensee has not sought advice from the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. This was confirmed by minutes of the meetings.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. S.84 The home did not develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care services, programs and goods provided to residents.
The manager of quality improvement confirmed that the home did not evaluate the effectiveness of the accommodation, care services, programs and goods provided to residents. The manager of quality improvement confirmed that the homes managers collect quality indicators however action was not always taken and an evaluation completed based on the analysis of information collected.
The food service supervisor confirmed that the expectation was for dietary staff to take and record temperatures of food in production and prior to service in each home area, however food temperature records confirmed that temperatures were consistently not taken and recorded in the main kitchen and home areas. Several residents interviewed expressed concerns with the temperature of foods served. The food service supervisor confirmed there was no process in place that monitored, analyzed and evaluated the process to improve the quality of dietary service provided to residents.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following subsections:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. S.44(7) The licensee did not ensure that Applicants # 800, #802 and # 803 were approved for admission to the home unless: a) the home lacks the physical facilities necessary to meet the applicant's needs b) the staff at the home lack the nursing expertise necessary to meet the applicant's needs c) circumstances exist which are provided for in the regulations as being grounds for withholding approval.
Note: This finding was issued in relation to an inspector initiated (other)inspection H-0000866-12
- Applicant # 800 was refused approval for admission to the home based on several behaviors.
- Applicant # 802 was refused approval for admission to the home based on the applicant being totally dependent for feeding of meals.
- Applicant # 803 was refused approval for admission to the home based on the applicant requiring maximum assistance for feeding at meal time.
Interviews with the Manager of Resident Services and the Education Consultant confirmed that these resident's were refused admission to the home for the reasons provided above.
The licensee refused approval for admission to the home based on reasons other that those allowed in the legislation.

Issued on this 6th day of September, 2012

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