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
Oct 28, 31, Nov 4, 7, 16, 2011; Jan 4, 5, 6, 2012	2011_071159_0022	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5

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

ASHA SEHGAL (159), SHARLEE MCNALLY (141)

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 administrator, director of care, food service manager, registered staff, personal support service workers, dietary staff, and resident regarding to inspection H-001922-11.

During the course of the inspection, the inspector(s) reviewed resident's health records (electronic medication administration record, daily food and fluid intake sheets, documentation record of bowel function, plan of care progress notes, reviewed the home's policy and procedures for continence and bowel management program and nutrition and hydration and pain management, interviewed identified resident and observed noon meal service.

Inspection 2011-070141-0038 for H-002118-11 was conducted simultaneously with inspection 2011-071159-0011 for H-001922011. This report includes findings for the written notifications #1 and #5 related to O.Reg79/10 s.8 (1)(b) and s.6.(10)(b) for inspection 2011-070141-0038 for H-002118-11.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Nutrition and Hydration

Pain

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. (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. (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. The plan of care for an identified resident did not provide clear directions for staff in relation to dehydration problem. In 2011 the plan of care was reviewed for this resident. The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) and the triggered Resident Assessment Protocol (RAP) Summary for an identified month in 2011, indicated that the resident was at risk for dehydration and the issue had been addressed in the written plan of care. However, the written plan of care did not address risk for dehydration as stated in the RAP summary. Resident's hydration status was not care planned with goals and interventions to provide clear directions to staff in resident's care needs.s 6 (1)(c)
2. An identified resident had not been reassessed and their plan of care reviewed at least every six months or at any other time when the resident's care needs change. Two quarterly reviews of resident's care needs were completed in a six month period in 2011 and identified the resident as having pain. The resident expressed a change in pain during an identified month in 2011, after surgery, and the resident received increased pain medication to address the expressed pain. A reassessment of pain was not completed at the time of change during this month. A Resident Assessment Protocol (RAPs) was not completed for pain for the two identified quarterly reviews to direct resident care needs. The written plan of care did not include non pharmaceutical approaches related to resident's pain needs. Registered staff could not identify where the pain RAPs should be recorded. s.6(10)(b)
The licensee did not ensure that an identified resident's plan of care was reviewed or revised when the resident's care needs changed. The resident had a history of high blood pressure and their blood pressure at the time of admission in 2011 was 112/73. The resident was receiving medication for high blood pressure once daily. The resident had a fall in 2011 and monitoring of vital signs was initiated. The resident's blood pressure dropped to a low reading during the first 24 hours post fall. After 24 hours it remained low. There was no revision to the plan of care related to resident's blood pressure changes. 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 written plan of care for all other residents sets out clear directions to staff and other who provide direct care to the resident, and the residents are reassessed and plan of care reviewed when care needs change,, to be implemented voluntarily.

WN #2: 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. There is no system in place to monitor and evaluate the food and fluid intake of residents.
The plan of care for an identified resident identifies that the resident was at high risk for low body mass index, weight loss, constipation and urinary tract infection. Resident had a plan of care to provide nutrition supplement and also fiber daily. There was no record of resident's intake of nutritional supplement and fibre and evaluation of the effectiveness of the nutritional interventions. Interview with the Registered Nurse and the Registered Dietitian confirmed that the nutritional supplement and fibre intake was not recorded.
The flow sheets identified that resident was refusing nourishment snacks frequently for multiple months in 2011, there was no record of resident's food and fluids intake evaluation. s.68(2)(d)

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 ensuring developing a system to monitor and evaluate the food and fluid intake of the identified resident and all other residents with order for nutritional supplements and dietary interventions for constipation, to be implemented voluntarily.

WN #3: 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. (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. The Registered Dietitian who is the member of the staff of the home did not assess an identified resident when there was a significant change in resident's condition and risk relating to hydration.
The resident's plan of care identified that resident had a Urinary Tract Infection (UTI) diagnosed in 2011.
There was no supportive documentation that the Registered Dietitian using an interdisciplinary approach completed nutritional assessment related the UTI and risk related to dehydration. The concern identified was discussed with the Registered Dietitian during the inspection. s.26(4)(a)(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 ensuring the Registered Dietitian who is the member of the staff of the home (a) completes a nutritional assessment for all residents whenever there is a significant change in a resident's health condition; and (b) assess hydration status and any risks relating to hydration, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following subsections:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. An identified resident was not assessed using a clinically appropriate assessment tool when the resident's pain was not relieved by initial interventions. The resident had surgery in 2011. Prior to surgery resident received narcotic pain medication three times a day and non narcotic pain medication for general pain. Post surgery the resident complained of increased pain and received narcotic pain medication multiple times as required for breakthrough pain. The narcotic pain medication was revised on multiple occasions in response to resident expressed pain. There was no assessment of pain using a clinically appropriate tool completed prior to the titration of the medication related to the resident's expression of increased pain. s.52,(2)

WN #5: 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 did not ensure that their Pain Program policy and procedure was complied with for an identified resident. The resident expressed increased pain needs related to surgery completed in 2011. The resident was receiving pain medication on multiple occasions as required for pain for breakthrough pain.
The licensee's policy states that pain assessments will be completed as part of a quarterly review of the resident's care needs. Residents on scheduled pain management medications will have a weekly summary completed which evaluates pain control measure and effectiveness of pain medication and will include communication with the resident to determine level and intensity of pain. The home's procedure states that documentation of the weekly assessments are to be completed in the resident's progress notes and a pain assessment should be completed quarterly using Point Click Care (PCC) if the resident Pain Score is more than 1 in the Resident Assessment Instrument (RAI).
The resident did not have consistent weekly assessments completed for the period of expressed pain and the assessments did not consistently include evaluation of the pain control, effectiveness of pain medication or resident input related to level and intensity of pain. The home confirmed that weekly assessments for residents with expressed pain were not being completed as per the licensee policy and procedure. s.8.(1)(b)
The licensee did not ensure that the policy and procedure for fall management was complied with for an identified resident. The licensee policy for Assessment of Falls states a post fall assessment is done at a minimum of every shift for the following 24 hours for potential complications from the fall. The assessment is documented in the electronic interdisciplinary notes. The resident had a fall in 2011 during the day shift. There were no falls assessments completed in the interdisciplinary notes for the following 2 shifts (evening and night shift) after the fall.

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 licensee policies, protocols and procedures are complied with,, to be implemented voluntarily.

Issued on this 6th day of January, 2012

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