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

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 public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 8, 9, 13, 14, 15, 2012	2012_071159_0009	Critical Incident

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

NORTHRIDGE
496 POSTRIDGE DRIVE, OAKVILLE, ON, L6H-7A2

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

ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Food Service Manager, registered staff, personal support service workers, dietary staff and residents.
H-00587-12

During the course of the inspection, the inspector(s) reviewed resident health records and plan of care for identified resident, reviewed policies and procedures related to provision of diets, menu planning, nourishment program and amended critical incident report. Interviewed staff regarding the critical incident.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

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. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA, 2007 S. O. 2007, c. 8, s. 6(1)(c)
The plan of care for an identified resident did not provide clear direction to staff in relation to fluid consistency when resident was having difficulty swallowing. The resident had a physician order for a pureed diet and thickened fluid honey consistency. Resident's accessible plan of care(hard Copy)specified pureed diet and thickened fluid nectar consistency. The plan of care was not revised to reflect thickened fluid consistency. The directions on the physician's order conflict with the directions on the plan of care.

The plan of care of the resident did not provide clear direction to staff in relation to self performance, support and assistance with feeding. The plan of care stated for self performance "eats independently with assistance or oversight", Support provided "needs to be fed" and for assistance "assist resident with eating when showing signs of fatigue" Interventions documented were conflicting and did not provide clear directions for staff.
2. LTCHA, 2007 S. O. 2007, c. 8, s. 6(7)
The licensee failed to ensure that care set out in the plan is provided to an identified resident as specified in the plan of care. The plan of care for the resident indicated provide assistance with eating. On May 8, 2012, the resident was observed at noon meal in dining room. The resident was served thickened beverages and beef soup. Resident appeared very tired and fatigued. When resident was approached and asked how she was managing. Resident responded " will you help me with eating" Personal support worker serving resident stated there were only 2 staff assigned to serve all residents and also to assist residents. She was busy serving food to residents and not available to assist the resident with eating. The staff did acknowledge and confirmed that the resident needed assistance.
The resident sat with a bowel of soup in front of her for over 10 minutes before she was assisted by a registered nursing staff. The registered nursing staff after feeding resident soup left. Resident was served main course, however, staff was not there to assist resident. The meal service was observed for a period greater than 40 minutes during which time no staff provided encouragement or assisted resident feeding main course and dessert. The uneaten meal plate was removed from the resident's table.

An identified resident had a plan of care to provide assistance with eating, and to encourage fluid intake. However, resident did not receive assistance with eating, or encouragement. Resident did not eat noon meal served or consume fluids. The plan of care identified resident at increased risk for dehydration due to fluid volume deficit, use of diuretics. The plan of care stated resident exhibits signs and symptoms of dehydration. Resident did not receive assistance with eating as specified in the plan of care.
3. The licensee has failed to comply with the LTCHA, 2007 S. O. 2007, c. 8, s. 6(10)(b)
The plan of care for an identified resident was not reviewed and revised when there was significant change in resident's heath condition. The resident had an unplanned weight loss 9.8% in one month. The plan of care for the resident did not include weight changes, interventions and strategies for weight loss.
4. The licensee has failed to comply with the LTCHA, 2007 S. O. 2007, c. 8, s. 6(11)(b)
The plan of care was not revised and different approaches considered when care set out in the plan of care had not been effective for the resident related to oral intake. The registered dietitian's notes, stated the resident receives 125 ml high protein pudding and puree fruits 3 x day at snacks. However, a review of resident's health record (progress notes, and food and fluid intake record) identified resident refusing most meals and snacks and continues to loose weight. There was no evidence of reassessment of current care set out in the plan of care or different approaches had been considered.

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 that plan of care is reviewed and revised when there was significant change in resident's heath condition, that the care set out in the plan of care is provided to the resident as specified in the plan of care and that the plan of care provide clear direction to staff to provide care to the resident, to be implemented voluntarily.

Issued on this 15th day of May, 2012

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

Ash Selpal