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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2018	2018_378116_0001	029339-17	Resident Quality Inspection

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Roberta Place
503 Essa Road BARRIE ON L4N 9E4

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

SARAN DANIEL-DODD (116), DIANE BROWN (110), ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 15, 16, 17, 18, 19, 22, 23, 28 & February 2, 2018.

A follow up inspection related to nutrition care and hydration programs was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Co-Director of Care, Assistant Director of Care, Nurse Managers, resident and Family Services Coordinator, Food Service Manager, Environmental Service Supervisor, registered staff members (RN) (RPN), registered dietitian, personal support workers (PSW), residents and families.
The inspectors observed the provisions of care, medication administration, and reviewed randomized resident clinical records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 68. (2)	CO #001	2016_393606_0006	110

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 2007, c. 8, s. 6 (11).
(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 ensure that when a resident is being reassessed and the plan of care is reviewed and revised because care set out in the plan had not been effective, have different approaches been considered in the revision of the plan of care.

The following findings are related to a follow up inspection regarding nutrition care and hydration programs which was conducted concurrently with this inspection.

Record review identified resident #016 was on fluid watch, as the resident's fluid goal remained unmet for an identified period and a "Nutrition: Hydration" referral was sent to the dietary department.
The referral response by the food service manager identified that resident #016 did not meet the daily fluid requirement for an identified period and the RD was to re assess the resident's daily fluid goal and the action recommended was for staff to continue to encourage fluid intake at meals, snacks and throughout the day. The RD's referral response identified the resident's preference of three servings of fluid, which had been established over an identified period, and adjusted/decreased the resident's fluid goal from the identified current goal per day to an established goal per day.

Further record review identified Nutrition: Hydration referrals sent on three separate occasions, for when resident #016's fluid goal remained unmet for an identified duration. No alternatives were considered in the food service response. On an identified date, the RD further adjusted/decreased the resident's fluid goal however, no alternatives were considered. The resident was again referred on two separate dates, with no changes to the plan of care or alternatives considered.

Record review identified the registered staff completed a required assessment, which identified the resident displayed signs and symptoms of an identified condition. The

action taken included notifying the SDM and initiating fluid monitoring. No alternatives were considered.

Record review of the resident's plan of care identified the implementation of a daily fluid goal on an identified date. The last prior update to the hydration plan of care was three months prior.

Interviews with PSW #118 revealed that they try and provide an established amount of fluids at each meal to resident #016. PSW #118 was unaware if the resident liked specific beverages and had never tried offering them and was only aware the resident liked an identified fluid. Interview with PSW #119 revealed the resident was on fluid watch and at risk of an identified condition. PSW #118 further revealed that staff push fluids as much as they can and that the resident prefers a specified fluid.
Interview with the DOC revealed the purpose of sending a hydration referral to dietary was to see if there was anything the RD can put in place from the dietary department.

Interview with the food service manager (FSM) revealed that upon receiving a referral they turn "on" the fluid watch task, which alerts staff to push fluids. The FSM stated that making available a variety of fluids according to the menu was the department's contribution.

Interview with the RD confirmed that when referrals were received and a resident's fluid goal not achieved that different approaches had not been considered in the revision of the plan of care and prior to reducing the resident fluid goal. The RD identified that they would look into ways to enhance a resident's fluid intake. [s. 6. (11) (b)]

2. Resident #017 was identified by the home at high nutritional risk. Record review identified resident #017 was on fluid watch as of an identified date, as the resident's fluid goal remained unmet for an identified period and a Nutrition: Hydration referral was sent to the dietary department.

Registered staff completed a risk assessment and the plan was to continue to encourage extra fluids throughout the day. The referral response by the food service manager identified the resident was on fluid watch and staff to continue to offer fluids throughout the day.

Further record review identified Nutrition:Hydration referrals sent on four separate dates, when resident #016's fluid goal remained unmet over an identified period.

Nursing completed identified assessments, no alternatives to improve fluid intake were considered. The referral response by the food service manager was to ensure the resident was on the fluid watch program, to refer to the RD and for staff to continue to offer fluids throughout the day.

Record review identified that on on an identified date, the RD had completed a fluid assessment and adjusted/decreased resident's fluid needs with no alternatives identified to improve the resident's fluid intake. Record review identified an additional nutrition hydration referral was sent, whereby resident's fluid goal remained unmet for an identified duration.

A review of the resident's hydration plan of care identified the last change was made three months prior.

Interview with the RD confirmed that resident #017 was not achieving the required fluid goal per day so it was adjusted and reduced. The RD acknowledged that different approaches had not been considered in the revision of the hydration plan of care. [s. 6. (11) (b)]

3. Record review identified nursing had completed an identified assessment for resident #018 and identified signs and symptoms of an identified condition. The plan included activating the home's Fluid Watch program. Staff interviews identified the Fluid Watch program alerts PSW staff to encourage residents to consume more fluids.

Further record review identified Nutrition: Hydration referrals were sent on three separate dates, for when resident's fluid goal remained unmet for an identified period. The referral response by the food service manager staff indicated to continue the fluid watch to encourage fluids at meals, snacks and in-between meals.

On an identified date, record review identified that the RD changed the resident's fluid goal from the current established goal per day with no changes to the hydration plan of care.
Record review identified nursing completed an identified assessment, for resident #018 and identified signs and symptoms of an identified condition. On a subsequent date, another Nutrition: Hydration referral was sent when the resident's fluid goal remained unmet for an identified period and a further Risk Assessment was activated.

Interview with PSW staff member #121 identified the resident at risk for an identified

condition and they push fluids as much as they can. RN staff member #109 further confirmed the resident was at risk for an identified condition and they encourage extra fluids.

Interview with the food service manager identified the resident was at risk for an identified condition and the resident was on the Fluid Watch program. The NM revealed that the resident was not on anything special from dietary and they provide fluids according to the menu.

An interview with the DOC identified that there were a lot of hydration referrals and acknowledged awareness that there was a lack of alternatives tried when the resident's fluid goal remained unmet.

Interview with the RD confirmed that the resident is at high risk for an identified condition, had altered skin integrity, required more fluid and that they had not tried a lot of alternatives to improve the resident's fluid intake. [s. 6. (11) (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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage one resident's #002 and #005 triggered for altered skin integrity to be further inspected.

The home's policy entitled "Skin and Wound Care Program" (version #III, revised 2017-02-20) documents that a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds; has a completed wound progress note weekly. This will reflect the weekly assessment of the resident related to altered skin integrity.

Review of the written plans of care for resident #002 and resident #005 indicated that they have altered skin integrity.

A review of the weekly skin notes for resident #002 for an established period revealed that weekly skin assessments for the area(s) of altered skin integrity were not completed on a consistent weekly basis as required.
A review of the weekly skin notes for resident #005 for an identified period indicated that weekly skin assessments for the area(s) of altered skin integrity were not completed for an identified period.

Interviews held with registered staff member #'s 106, 107,108,109 and 110 indicated being aware of resident #'s 002 and #005 altered skin integrity and the requirement for weekly skin assessments to be conducted.
Further interviews held with the DOC and the Administrator confirmed that the altered skin integrity for resident #002 and #005 were not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

Issued on this 22nd day of February, 2018

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

Original report signed by the inspector.