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
Dec 16, 2013	2013_108110_0016	T-501-13	Complaint

Licensee/Titulaire de permis

BARRIE LONG TERM CARE CENTRE INC.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

DIANE BROWN (110)

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): September 27th, October 2nd and October 8th, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Registered Staff, Registered Dietitian, Food Service Manager, Food Service Workers, Personal Support Workers, Residents

During the course of the inspection, the inspector(s) Monitored meal and snack service, reviewed resident health records, reviewed relevant polices and procedures

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	
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. (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; 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 the care set out in the plan of care is provided to the resident as specified in the plan.
Resident #1, at high nutritional risk had nutrition interventions identified in their plan of care. The food service manager confirmed that the nutrition interventions were required to be in place.
On an identified date, lunch and afternoon snack pass were observed. Observations and staff interviews revealed that nutrition interventions for Resident #1 were not provided as set out in the plan.

On an identified date, observations and an interview with a food service worker confirmed that Resident #1 had not been receiving a planned nutrition intervention, for six weeks, as the intervention had not been implemented. [s. 6. (7)]

2. The licensee has failed to 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 care set out in the plan of care has not been effective.
Record review indicated that nutritional concerns were identified for Resident #1.
Record review and staff interviews revealed that a nutritional assessment had not been completed by the registered dietitian to address these two concerns and resident's plan of care had not been reviewed and revised.

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 care set out in the plan of care is provided to the residents as specified in the plan and the resident is reassessed and the plan of care reviewed and revised at any other time when care set out in the plan of care has not been effective, to be implemented voluntarily.

WN #2: 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. The licensee failed to ensure that residents with a change of 5 per cent of body weight, or more, over one month are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.
Resident #1 was at high nutritional risk. Record review and staff interview revealed that Resident #1's significant weight loss of 5.1% between two identified months was not assessed with actions taken and outcomes evaluated.

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 residents with a significant change of body weight, or more, over one month are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are offered a minimum of a snack in the afternoon and evening.
Resident #2 is at high nutritional risk requires staff assistance with eating.
On an identified date, observations of the afternoon snack pass on an identified unit and interview with the staff member serving the snacks confirmed that resident #2 was not offered an afternoon snack.

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 residents are offered a minimum of a snack in the afternoon, to be implemented voluntarily.

WN #4: 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. (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 that the registered dietitian who is a member of the staff of the home assess the resident's nutritional status, including height, weight and any risks related to nutrition care.
Resident #1's had a nutritional risk related to increased energy needs. Record review and an interview with the registered dietitian revealed that Resident #1's diagnosis and impact on energy needs was not a component of the nutritional assessments. An estimated nutritional requirement for energy needs was not calculated and compared with an estimated nutritional intake. As a result, it was unclear to the registered dietitian if adequate energy to compensate for Resident #1's high energy expenditure was being offered. Resident #1 continued to have slow progressive weight loss.

2. The licensee failed to ensure that the registered dietitian who is a member of the staff of the home assess the resident's nutritional status, including height, weight and any risks related to nutrition care.
Resident # 3 had a nutritional risk related to a significant unplanned weight loss between two identified months. Record review and an interview with the registered dietitian revealed that Resident # 3's energy needs was not a component of the nutritional assessment. An estimated nutritional requirement for Resident #3's energy needs was not calculated and compared with an estimated nutritional intake. As a result, it was unclear to the registered dietitian if adequate energy to compensate for unplanned weight loss and maintain goal body weight as identified in his plan of care was being offered. Resident lost 4.8 kilograms the following month. [s. 26. (4)]

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Issued on this 31st day of December, 2013

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

Diane Brown