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 # / Registre no	Type of Inspection / Genre d'inspection
Jun 22, 2017	2017_597655_0010	007543-17	Complaint

Licensee/Titulaire de permis

The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott
c/o St. Lawrence Lodge 1803 County Road 2 BROCKVILLE ON K6V 5T1

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

ST. LAWRENCE LODGE
1803 County Road, #2 East Postal Bag #1130 BROCKVILLE ON K6V 5T1

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

MICHELLE JONES (655)

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): June 7 and 8, 2017.

During this inspection complaint, Log #007543-17, related to food quality and menu planning, social and recreation activities, and medications was inspected.

During the course of the inspection, the inspector(s) spoke with residents and family, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Activation staff, Food Services staff, the Nutrition Manager, an Assistant Director of Care (ADOC), and the Director of Care (DOC).

During the course of the inspection, the inspector also observed the provision of resident care and services; and, reviewed resident health care records, licensee policies and procedures, menus and documentation related to menu planning and nutritional analysis.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Food Quality
Medication
Nutrition and Hydration
Recreation and Social Activities
Responsive Behaviours

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

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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee has failed to ensure that there is a written plan of care for resident #003 and for resident #004 that sets out: the planned care for the resident, the goals the care is intended to achieve; and, clear directions to staff and others who provide direct care to the resident.

Resident #003 was admitted to the home on a specified date, with multiple diagnoses. On review of resident #003s' health care record, it was noted that resident #003 had a history of exhibiting responsive behaviours. In the health care record, three specific behaviours were described; and several triggers and strategies were identified related to resident #003s' behaviours. In the most recent Minimum Data Set (MDS) assessment, it was indicated that resident #003 continued to exhibit the same responsive behaviours.

During the inspection, PSW #108 described resident #003s' behaviours to Inspector #655, and identified specific triggers for those behaviours. PSW #108 indicated to Inspector #655 that one of the specific strategies used to address a specified behaviour was not effective when it was implemented on the same day of the interview. PSW #108 was not aware of at least one of the strategies that was identified in the residents' health care record as being effective in managing resident #003s' behaviours. PSW #108 indicated to Inspector #655 that when needed, registered nursing staff could also administer a medication to resident #003.

Inspector #655 reviewed resident #003s' care plan and was unable to locate any documentation within the care plan related to resident #003s' responsive behaviours as they were described in the residents' health care record. In the care plan, the specific behaviours exhibited by resident #003 were not identified; and accordingly, there were no identified goals of care or clear directions for managing those behaviours in the care plan. In the care plan, it was, however, indicated that resident #003 was to receive a specified type of medication in order to manage specific conditions that were related to the residents' behaviours.

Resident #004 was admitted to the home on a specified date with multiple diagnoses. Inspector #655 reviewed the progress notes for resident #004 and found several instances within a period of six months where resident #004 had exhibited responsive behaviours.

Inspector #655 reviewed resident #004's care plan. In resident #004s' care plan, it was

indicated that resident #004 demonstrated responsive behaviours, but the specific behaviours were not identified. In addition, neither the planned care related to resident #004s behaviours nor the goals that care was intended to achieve were set out. Accordingly, there were no clear directions in resident #004s' care plan related to strategies for managing resident #004s’ behaviours.

During the inspection, PSW #108 indicated to Inspector #655 that resident #004 has responsive behaviours. PSW #108 described specific behaviours but was not aware that resident #004 had a history of demonstrating certain behaviours that were described in the residents’ health care record. PSW #108 identified three specific triggers for resident #004s’ behaviours. However, PSW #108 was unable to speak to what information was included in resident #004s’ plan of care related to behaviours.

According to PSW #108, staff who are providing direct care to residents’ are expected to refer to the residents’ care plan for information related to a residents’ plan of care – including information related to a residents’ behaviours. Over the course of the inspection, this was confirmed by RPN #107 and the DOC.

During the inspection, the DOC reviewed resident #004s’ care plan with Inspector #655. The DOC was not aware that resident #004 had exhibited responsive behaviours. On review of the care plan by the DOC, it was confirmed that there was no indication that resident #004 demonstrated specific behaviours in the care plan nor were there any identified strategies for managing those behaviours in resident #004s' care plan. The care plan did not set out the planned care or the goals of care related to resident #004s' behaviours. Accordingly, there were no clear directions for managing resident #004s' behaviours included in resident #004s’ care plan.

The licensee failed to ensure that there was a written plan of care related to responsive behaviours for resident #003 and for resident #004 that sets out: the planned care for each resident, the goals the care is intended to achieve; and, clear directions to staff who provide direct care to the residents.

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 written plan of care for each resident, including resident #003 and resident #004, sets out the planned care for each resident, the goals the care is intended to achieve, and clear directions to staff and others who provide direct care to the resident, related to responsive behaviours,, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure that each resident is offered a snack in the afternoon and evening.

During the inspection, Inspector #655 observed an afternoon snack pass on a resident home area.

At that time, Inspector #655 interviewed the staff member who was observed to be conducting the pass, PSW #112. PSW #112 indicated to Inspector #655 that all residents are to be offered a snack twice daily – once in the afternoon, and once in the evening. PSW #112 indicated to Inspector #655 that when a snack has been offered to a resident, the acceptance or refusal of the snack by each resident is documented on a "Snack Intake Sheet". PSW #112 further explained that if the resident was absent (i.e. not in their room or not seen to be on the unit) during the snack pass, it would be documented on the Snack Intake Sheet with a notation: "A" for "Absent". During the same interview, PSW #112 indicated to Inspector #655 that many residents were off-unit at the time of the afternoon snack pass on the day of the observation because they were participating in a specified activity at the same time. PSW #112 was unsure if those residents who had chosen to participate in the afternoon activity that day would be offered an afternoon

snack.

Inspector #655 reviewed the "P.M./H.S. Beverage/Snack Intake Sheet" (the Snack Intake Sheet) for a specified week. For each day, there are four columns for each resident - pm-s (afternoon snack), pm-f (afternoon fluid/beverage), hs-s (bed time snack), hs-f (bed time fluid/beverage). It was noted that on page two, six residents out of eleven were marked as “A” or “Absent” for the afternoon snack and beverage pass on the day of the above observation, including resident #003.

Resident #003 was admitted to the home with multiple diagnoses. Risks related to nutrition were identified in resident #003s’ care plan.

During an interview, resident #003 indicated to Inspector #655 that on some days, he/she is not offered an afternoon snack. Resident #003 explained to Inspector #655 that on some afternoons, he/she is participating in an activity when the snack pass is conducted. Resident #003 indicated to Inspector #655 that if the nourishment (snack) cart is no longer on the unit when he/she gets back from the activity, he/she is "out of luck"; and will not be offered a snack. Resident #003 did not recall receiving a snack on the day that Inspector #655 observed the snack pass.

According to a family member of resident #003, resident #003 is often off-unit (on another floor) during a nourishment pass; and, on return to the unit, is not offered a snack or beverage. According to the family member of resident #003, this is a common occurrence.

During the inspection, PSW #108 indicated to Inspector #655 that the afternoon snack pass usually occurs at 1400 hours. PSW #108 indicated to Inspector #655 that if a resident is off-unit at an activity at the time of the snack pass, they may not be offered a snack that afternoon. PSW #108 indicated to Inspector #655 that sometimes dietary removes the nourishment cart from the resident home area before the residents have returned from the afternoon activity; in which case the resident would not be offered a snack.

During the inspection, RPN #107 indicated to Inspector #655 that the nourishment cart normally remains on the residents' home area until 1500 hours. During the same interview, RPN #107 directed Inspector #655 to refer to the Snack Intake Sheet in order to determine whether or not a resident, such as resident #003, had received a snack when the resident returned from an activity that took place during a nourishment pass.

Inspector #655 reviewed the "P.M./H.S. Beverage/Snack Intake Sheet" (the Snack Intake Sheet) for a specified week. At the time of this review of the Snack Intake Sheet, Inspector #655 observed that there was still an "A" for absent next to resident #003 for the afternoon snack pass that Inspector #655 had observed some time before. It was noted at the same time, that resident #003 was also marked absent for the afternoon snack pass on a second specified day. Resident #003 was again off-unit during the nourishment pass on that second day. Moreover, it was noted that there was no documentation on the Snack Intake Sheet to indicate that an evening (HS) beverage/snack was offered to any of the eleven residents listed on page two for two specified dates within a period of one week. It was further noted that four out of eleven residents were marked as "absent" for two-three out of four afternoon snack passes; with two other residents marked "absent" for one out of four of the afternoon snack passes over the same one week period.

During an interview, Activation staff #111 indicated to Inspector #655 that resident #003 would not have been offered a snack during an activity off-unit, as it is expected that the snack would be offered to the resident upon returning to the residents' home area.

During an interview, the DOC also indicated to Inspector #655 that it would be expected that a resident is offered an afternoon snack upon returning to the resident home area after an activity. The DOC explained that staff conduct one pass for the afternoon snack; but that the cart would normally remain on the unit after the pass, so that a snack would be available to residents' who wish to obtain one.

The licensee failed to ensure that that each resident, including resident #003, is offered a snack in the afternoon.

Issued on this 23rd day of June, 2017

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

Original report signed by the inspector.