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

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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
Aug 16, 17, 18, 19, 2011	2011_063165_0016	Complaint

Licensee/Titulaire de permis

ST. PETER'S CARE CENTRES
125 Redfern Ave, HAMILTON, ON, L9C-7W9

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

ST. PETER'S RESIDENCE AT CHEDOKE
125 Redfern Avenue, HAMILTON, ON, L9C-7W9

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

TAMMY SZYMANOWSKI (165)

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 the administrator, the director of care, the associate director of care, the resident assessment instrument coordinator, registered staff and the registered dietitian.

During the course of the inspection, the inspector(s) reviewed resident clinical health records and reviewed policy 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	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 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. The licensee of the home did not ensure that the nutrition and hydration programs included a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.
The home did not have a system in place that monitored and evaluated the fluid intake of residents with identified risks related to hydration. The director of care and associate director of care confirmed that there was no formalized system that identified residents with risks related to hydration if they experienced a decline outside of their quarterly review time period. The homes referral form to the dietitian did not include hydration as an indicator to identify residents at hydration risk and there was no system that included a process for the evaluation of fluids for residents with identified risks related to hydration.
2. The hydration program did not include the development and implementation of a policy and procedure related to hydration. The director of care and associate director of care confirmed that the home did not have a policy that included procedures for staff to monitor and identify residents at risk for dehydration outside of their quarterly review time period.

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 nutrition care and hydration program includes 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 and a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, to be implemented voluntarily.

WN #2: 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. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

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 dehydration resident assessment protocol (RAP) completed by a member of the nursing staff for an identified resident indicated dehydration was triggered by insufficient fluid consumption for three consecutive days. The RAP indicated that dehydration and fluid maintenance would be care planned and that the resident was at risk for dehydration and urinary tract infections related to poor intake however, there was no plan of care developed for the resident to address the dehydration risks.
A plan of care was not based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's: hydration status and any risks relating to hydration.
Upon returning from a doctors appointment family indicated that it was recommended to push fluids and watch for signs of urinary infection however, there was no plan of care developed to address the resident's hydration needs.
The resident was later admitted to hospital.
2. A dehydration resident assessment protocol (RAP) was completed by a member of the nursing staff and indicated that an identified resident was responding to the interventions as outlined in the plan of care. Her clinical assessment had not changed from the last assessment and care plan goals and interventions were reviewed by the care team members to be effective in preventing the RAP problem however, there was no dehydration plan of care developed.
3. The licensee did not ensure that a registered dietitian who is a member of the staff of the home, assesses the matters referred to in paragraphs 13 and 14 of subsection (3). The homes dietitian did not assess an identified resident's hydration status and any risks related to hydration.
The resident's fluid consumption had declined however, the dietitian confirmed that an assessment of the resident's hydration status and risks related to hydration was not completed despite an awareness of low consumption.

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 a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: hydration status and any risks relating to hydration and that a registered dietitian who is a member of the staff of the home assess hydration status and any risks relating to hydration, to be implemented voluntarily.

WN #3: 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. 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 did not ensure that the plan, policy, protocol, procedure strategy or system was complied with.
The home did not ensure that their Elimination-bowel care policy (#370) was complied with in accordance with 8(1)(a) of the Act in relation to nursing and support services for an identified resident. The medical directive indicated if there are complaints of constipation or abdominal pain, do an abdominal assessment and a rectal check. Call physician if assessment findings warrant. If no bowel movement after two days give Senekot 2 tabs orally or Dulcolax 10mg suppository (if stool present). If no results may repeat on day three. If no results by day four notify Physician.
The resident's bowel records indicated that the resident did not have a bowel movement for four consecutive days in 2010 however, the medication administration record (MAR) and clinical record indicated that interventions were not provided. The resident's bowel records indicated that the resident did not have a bowel movement for four consecutive days on two separate occasions in 2010 however, the MAR's and clinical record indicated interventions were not provided by staff until the fourth day.

WN #4: 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. (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).

Findings/Faits saillants :

1. An identified resident was not reassessed and the plan of care reviewed when the resident's care needs changed. An identified resident returned from an appointment with recommendations to push fluids and monitor for signs of infection. The resident's fluid intake declined and presented with signs of infection however, there was no reassessment and review of his plan of care when his care needs changed. The resident was transferred to hospital.
2. An identified resident did not receive care that was set out in the plan of care.
The physician ordered blood pressures to be taken daily however, the resident's clinical record did not indicate that blood pressures were taken on at least twenty-two out of thirty-one days in 2011.
A lab test was ordered by the physician for a resident however, this order was not followed through by staff.

Issued on this 1st day of December, 2011

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