Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 22, 2020	2020_714673_0004	008022-20, 013154-20	Complaint

Licensee/Titulaire de permis

Villa Colombo Seniors Centre (Vaughan) Inc.
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

Villa Colombo Seniors Centre (Vaughan)
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

BABITHA SHANMUGANANDAPALA (673)

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): July 16, 17, 20, 21, 22, 23 (off-site), 24, 28, 29, 30, 31, August 4, 5, 6, 7 (off-site), 10, 11, 12, September 15-17 (off-site), 21-25 (off-site), 2020.

The following intakes were completed during this inspection:
-Log #008022-20 related to infection prevention and control, medication management, skin and wound care, and continence care
-and Log #013154-20 related to an allegation of neglect.

A non-compliance identified during this inspection under s. 221 (1) was issued under complaint inspection report # 2020_766500_0007 which was completed concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Interim Administrator, Corporate Clinical Manager, Assistant Director of Care (ADOC), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeepers, Food Service Manager (FSM), housekeepers, Dietary Aides, summer students, residents and family members.

During the course of the inspection, the inspector(s) observed the provision of care to residents, residents' care areas, meal services, and reviewed the residents' and the home's records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 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	Légende 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The Ministry of Long-Term Care (MLTC) received a complaint regarding concerns about medication administration for resident #003. In an interview, the complainant stated that staff were administering identified medications to resident #003 despite the resident having a symptom associated with an infection and treatment for it.

A review of resident #003's diagnostic test results showed that resident #003 had an infection. Review of resident #003's Electronic Medication Administration Record (EMAR) for that month indicated that they were ordered to have an identified treatment for an identified number of days starting the following day. It also showed the resident had multiple identified medications for treatment of an identified condition.

Review of the Point of Care (POC) report indicated resident #003 experienced a mild form of the symptom on the first day of their treatment. Review of the EMAR indicated the identified medications were still administered by RPN #143, RN #144 and RPN #147.

In interviews, RN #144 and RN #143 stated that if a resident is having this symptom, they would hold the identified medications, monitor the resident and inform the physician.

RN #144 stated that they were not aware of resident #003 experiencing the symptom on the first day of their treatment as no one had reported anything to them. RPN #143 stated they were aware through reports by the PSWs of resident #003 having the identified symptom almost every day of their treatment and they had reported the incidents to the charge nurse. RPN #143 held the identified medications after being informed of the symptom by the complainant 2-3 days after the treatment was started.

Further review of resident #003's EMAR indicated that they were administered the identified medications the second and third day of their treatment. Most of the administration was completed by RPN #148; however, RPN #148 could not be contacted for an interview.

In audio recordings from the third day of treatment, the complainant and PSW #117 are heard informing RPN #148 that resident #003 had been having the identified symptom due to the treatment. Later that same day, PSW #117 and the complainant are heard describing the resident having the identified symptom and the resident is heard moaning in the audio recording. Review of the Point of Care (POC) report did not show that resident #003's symptom was documented by the PSW.

In the recording, the complainant informs PSW #117 that resident #003 has had this symptom for every day for the last six days and that no one had reported it because they were all agency staff caring for the resident. Review of the Point of Care (POC) report did not show that resident #003's symptom was documented by the PSW.

In an interview, the complainant further stated that on the third day of treatment, RPN #148 came in to administer resident #003's medications which included an identified medication. The complainant told RPN #148 that the resident should not be given the identified medication because of their symptom but the nurse stated to give it because the medications had already been mixed and that the resident could be monitored, and the medications could be held the next time if needed. In the recording provided by the complainant, they are heard requesting evening RPN #143 to re-prepare the medication without the identified medication to which RPN #143 obliged.

The home failed to ensure that the staff involved in the different aspects of care for resident #003 collaborated with each other in the development and implementation of the plan of care so that the medication and symptom management aspects of care were integrated, consistent with and complemented each other. Resident #003 experienced a symptom on the first, second and third day of an identified treatment; however, was still

administered identified medications by the registered staff until the complainant intervened on the third day of the treatment. [s. 6. (4) (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 that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with directions for use specified by the prescriber.

a) The MLTC received a complaint regarding neglect of resident #003's skin care. In a recording provided by the complainant, PSW #117 is heard saying that staff were putting too much of a specified medication and that they had once found a lot of it in an identified region of resident #003's body so they hid the specified medication.

In an interview, PSW #117 corroborated the audio recording statement and stated they had been very upset to find that amount of the specified medication in an identified region of resident #003's body and had removed the specified medication to prevent it from happening again. PSW #117 further stated they had reported the finding to another staff member but could not remember who.

Review of resident #003's EMAR indicated that the resident was ordered to have the specified medication applied a number of times a day to two identified body regions for skin protection. It further stated that it should not be applied to the identified region the medication was found in by PSW #117.

Review of the resident #003's EMAR showed no signatures on ten days that month to indicate that the specified medication was administered, nor was documentation found elsewhere in resident #003's medical records to identify why it had not been administered.

b) The MLTC received a complaint regarding concerns about medication administration and food and fluid intake for resident #003.

Review of resident #003's EMAR indicated that they were ordered to have a specified medication twice a day at two specified times with two identified meals if they ate more than 50% of their meal.

In an interview, RPN #146 stated that they always ask the PSWs assigned to the resident if they had their meals before administering the specified medication.

Review of resident #003's POC documentation for nutrition, eating and snack supplement indicated that they had refused the two identified meals on a specified date, but review of the EMAR indicated that the specified medication was still administered to them by RPN #146.

In addition, review of resident #003's EMAR showed no signatures on five additional specified dates to indicate that the specified medication was administered, nor was documentation found elsewhere in resident #003's medical records to identify why it had not been administered. Review of resident #003's POC documentation for nutrition, eating and snack supplement indicated that they ate more than 50% for one identified mealtime on one of these specified dates, and another identified mealtime on another one of these specified dates. [s. 131. (2)]

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 drugs are administered to residents in accordance with directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

As per O. Reg. 79/10, s. 5. “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Review of the home's policy titled Zero Tolerance to Resident Abuse and Neglect, policy #RC 01-01-12, dated 2018-10-07, indicated that neglect includes inadequate provision of physical requirements such as food and medicine as well as inadequate hygiene and personal care. Indicators of neglect included impaired skin integrity, ulcers, central nervous system depression and not being assessed by a physician.

A) The MLTC received a complaint regarding concerns about continence care for resident #003 and neglect of resident #003’s skin and wound care.

i) The complainant stated that resident #003’s plan of care to be changed every three

hours and repositioned every two hours was not being followed as the home had changed their work and nourishment schedules.

Review of resident #003's written plan of care indicated a scheduled toileting program where the resident was to be checked and changed in bed every three hours or as needed with total assistance by an identified number of staff. Further review of resident #003's plan of care indicated a recurring identified skin alteration on an identified part of their body noted from a specified date. Interventions included to follow facility protocol/regime in treating breaks in skin integrity by seeing the Electronic Treatment Administration Record (ETAR) for treatment and turning and repositioning the resident every two hours. Interventions included documenting on the POC flow sheets if skin is intact or if it is altered.

Review of the daily schedule indicated that the work schedule had been changed to 12-hour shifts starting on an identified date. In an interview, PSW #117 stated that they were aware that nourishment was normally started around 1930hrs but when the evening shift started at 1800hrs, they were immediately serving nourishment instead of checking and changing residents. In an interview, RPN #143 stated that they had switched the schedule for nourishment to 1800hrs.

In an interview, PSW #117 stated that during their day shift from 0700hrs-1900hrs, they changed and provided continence care to resident #003 every 2-3 hours with the last continence care being provided at 1530-1600hrs. In an audio recording provided by the complainant where they request to know resident #003's toileting schedule, PSW #117 informs them that resident #003 was provided toileting at 0600hrs, 1000hrs and 1430hrs.

The complainant reported that on a specified date, they requested the day PSW #117 to change the resident to which PSW #117 stated to wait until the evening shift PSW arrived at 1800hrs. At 1800hrs the complainant requested the evening PSW to assist them in changing resident #003 as they had had a bowel movement at 1700hrs. At 1800hrs, the evening PSW agreed to help, but was then observed by the complainant at 1845hrs providing nourishment. The complainant then requested RPN #143 at approximately 1900hrs for assistance to which RPN #143 responded they would assist in 30 minutes. The complainant began changing the resident at 1930hrs after which time RPN #143 joined to assist. The complainant reported resident #003 was left in feces for 2.5 hours.

In an audio recording provided by the complainant, the day after the specified date noted

above, the complainant is heard expressing concerns to PSW #117 about the evening PSW starting to serve nourishment/snacks at 1800hr shift change without checking and providing continence care to the residents first. PSW #117 is heard stating that this is incorrect as dinner is served from 1700-1800hrs and it doesn't make sense to serve nourishment/snacks at 1830hrs, and it should be served at least at 1900hrs. PSW #117 further states that all PSWs are trained to check their residents first at shift change and provide continence care before nourishment. PSW #117 is heard addressing the evening PSW with the same concern as they were providing nourishment at 1800hrs. The complainant is then heard addressing RPN #143 with this concern to which RPN #143 responds that nourishments will be done first before residents are changed.

In an interview, RPN #143 acknowledged that providing nourishment at 1800hrs meant that residents were not being checked, changed as needed and/or repositioned as needed at change of shift.

ii) On a specified date, when RPN #143 was assisting in changing the resident, the complainant observed a specified form of altered skin integrity to an identified location of resident #003's body. The complainant showed RPN #143 and requested them to implement a specified intervention to the altered skin integrity. The complainant reported that RPN #143 refused to implement the specified intervention they requested stating resident #003 had an identified form of incontinence and the specified intervention would injure the area. RPN #143 instead implemented a different identified intervention to the altered skin integrity.

In an interview, RPN # 143 stated that if skin alteration is observed on a resident, the home's expectation is to clean the resident, apply barrier cream or a dressing as required, reposition the resident every two hours, make a referral to the dietitian, inform the doctor, obtain an order as needed and update the written plan of care through documentation.

In an interview, RPN #143 stated that during their night shift on the specified date noted above, they were made aware by the complainant of an identified form of skin alteration to an identified location on resident #003's body and implemented an identified intervention to the altered skin integrity

Review of the POC documentation for skin condition, progress notes, and other medical documents indicated that no documentation, referrals or assessments of the altered skin integrity were completed on the specified date.

In an interview, RPN #143 acknowledged that no documentation was made about this observation and identified intervention, an assessment was not completed, a referral to the dietitian was not made, and the physician was not informed on the specified date, after becoming aware of resident #003's identified form of altered skin integrity. RPN #143 stated that the identified form of altered skin integrity looked worse the following day on their night shift.

iii) The complainant reported that the day after they noted the specified form of altered skin integrity to resident #003, they called the RPN on duty and the RPN was not aware of resident #003's specified form of altered skin integrity. Review of the home's daily staff roster indicated that RPN #148 was working that day. The complainant stated they informed RPN #148 about resident #003's specified form of skin alteration and asked them to reposition them and implement a specified intervention to the altered skin integrity. RPN #148 stated that they were administering residents' medications and would complete the task after a certain hour. The complainant reported that they arrived to the unit four hours later, and the specified intervention that they had requested had still not been implemented to resident #003's specified form of altered skin integrity.

In an audio recording provided by the complainant, on this same day, RPN #148 is heard entering resident #003's room and applying the specified intervention requested by the complainant to resident #003's altered skin integrity. Review of the POC documentation for Skin condition indicated that on this day, resident #003 had a new specified form of altered skin integrity to an identified part of their body. Review of the medical documentation did not show a skin and wound assessment, a physician's order or documentation related to the specified intervention administered by RPN #148 on this date to resident #003. RPN #148 could not be contacted for an interview.

Later in the same recording, PSW #117 and the complainant are heard agreeing to change the resident's incontinence product, and PSW #117 and the complainant are heard describing the resident having an identified form of incontinence, with a reddened face while shaking. The resident is heard moaning in the audio recording. The specified intervention to the specified form of altered skin integrity needed to be redone after the continence care was provided. In the recording, PSW #117 is heard stating that the resident has a specified form altered skin integrity that really needs a specified form of intervention as the kind of incontinence that resident #003 was having could injure their skin and altered skin integrity and wonders out loud why the specified intervention had not been done the day before.

In another audio recording provided by the complainant from the same day, at shift change, RPN #143 is heard having an exchange with the complainant where RPN #143 states that the complainant had not mentioned the specified form of altered skin integrity the day before, and that they had observed a different identified form of altered skin integrity for which an identified intervention had been implemented. The complainant states they had informed RPN #143 about the specified form of altered skin integrity the day before and asked them to apply a specified intervention to which RPN #143 had refused. RPN #143 is heard assisting to apply the requested specified intervention to resident #003's specified form of altered skin integrity during which time resident #003 is heard moaning. The complainant is heard showing the specified form of altered skin integrity to RPN #143 again stating that they had requested a specified intervention yesterday. RPN #143 screams upon seeing the specified form of altered skin integrity and apologizes that they had not seen it yesterday. RPN #143 then applied an identified topical antiseptic to the specified form of altered skin integrity and implemented the requested specified intervention.

In an interview, RPN #143 stated that an order from a physician is required to put anything on an area of impaired or altered skin integrity including the identified topical antiseptic. RPN #143 stated that they became scared as they had not seen the specified altered skin integrity the day before, and didn't want it to get infected, so they applied the identified topical antiseptic. RPN #143 stated that they didn't know why they had not informed the doctor that same day.

A review of the progress notes dated two days following the day the complainant noted the specified form of altered skin integrity to resident #003, indicated that RPN #147 implemented a specified intervention to a specified form of altered skin integrity on an identified location of resident #003's body. However, review of the documentation did not indicate that the physician was notified, a skin and wound assessment was completed, or that an order was obtained for the specified intervention for resident #003 on this day.

iv) RPN #143 documented referrals made to the physiotherapist and dietitian two days following the day the complainant noted the specified form of altered skin integrity to an identified location of resident #003's body . A review of the assessments indicated that both the dietitian and physiotherapist assessments were not completed until 10 days later.

Review of the assessments completed for resident #003 on POC indicated that a skin

and wound care assessment was not completed until three days after the day the complainant noted the specified form of altered skin integrity to resident #003. Review of the skin and wound care assessment completed six days thereafter, indicated that resident #003 had an identified form of altered skin integrity that had worsened.

Review of the progress notes indicated that the physician was not contacted for an order for the specified form of altered skin integrity until three days after the day the complainant noted it.

Resident #003's skin and wound care was neglected as an assessment and documentation were not completed by RPN #143 on the day the complainant made them aware of resident #003’s altered skin integrity. The altered skin integrity worsened the following day and a specified form of intervention was not implemented until 1500hrs despite the complainant informing RPN #148 at 0830hrs. When RPN #148 eventually implemented the specified intervention to the altered skin integrity after 1500hrs, they did not have any orders for the specified intervention from the physician, did not complete an assessment, nor document the care provided. When RPN #143 re-implemented the specified intervention to the altered skin integrity that evening, they did so again without an order, and also applied an identified topical antiseptic without a physician’s order. A physician was not contacted for the specified intervention to the altered skin until three days after the day the complainant noted it, and dietitian and physiotherapist assessments were not completed until 12 days after the complainant made staff aware of resident #003’s altered skin integrity.

In an interview, RN #147 acknowledged that resident #003’s skin and wound care had been neglected.

B) The MLTC received a complaint regarding infection prevention and control issues within the home.

In an interview, the complainant stated that they had been contacted by the home to inform them that resident #003 had a specified symptom on an identified date. A review of the progress notes on this identified date indicated that resident #003 was placed on isolation precautions and was treated for their symptom.

Review of the physician’s orders the next day indicated orders for two identified diagnostic tests, vitals every four hours, swab for an identified disease of public health significance, and management as needed with an existing order for an identified

antipyretic/analgesic.

Review of resident #003's medical records did not indicate that one of the identified orders for a diagnostic test was completed. A review of resident #003's medical records also indicated that the other identified diagnostic test was not completed until 17 days later, at which time it showed abnormal values.

A progress note by ED #101 dated three days after resident #003 was first noted to have a specified symptom stated that they informed the complainant that the results for resident #003 had come back negative for an identified disease of public health significance.

A progress note by ED #101 dated six days after resident #003 was first noted to have a specified symptom stated they updated the complainant of resident #003's symptoms that day. ED #101 also documented a request by the complainant for follow up with resident #003 to rule out other causes of the symptoms. In an interview, the complainant stated that they had requested ED #101 to have the interdisciplinary team follow up with resident #003 and perform other assessments/diagnostic tests to identify and treat the root cause of the symptoms. The complainant stated that ED #101 agreed to do so and get back to the complainant.

Review of the progress notes and physician's orders dated six days after resident #003 was first noted to have a specified symptom indicated orders to increase the dosage of the antipyretic/analgesic and orders for identified diagnostic tests to rule out a specified infection.

Review of resident #003's medical records did not indicate that the above orders for the identified diagnostic tests were fulfilled.

Review of the progress notes dated seven, ten and eleven days after resident #003 was first noted to have a specified symptom indicated that resident #003 continued to show the same symptom.

Review of the York Public Health's Respiratory Outbreak Line Listing indicated that resident #003 was tested for an identified disease of public health significance one, three and twelve days after they were first noted to have a specified symptom and the results all came back negative.

In an interview, the complainant stated that upon seeing resident #003 eleven days after they were first noted to have a specified symptom, they observed that there had been a severe decline in resident #003's health. The complainant requested the staff nurse to call the physician to assess resident #003.

In an interview, PSW #117 stated that they had noticed resident #003 had discharge coming from specified parts of their body and had reported it to a nurse two to three days prior to the complainant's visit but could not remember which nurse. Review of resident #003's medical records did not show documentation indicating a nurse had been informed or any action had been taken in relation to resident #003's infection to specified parts of their body two to three days prior. Review of the physician's orders on the date that the complainant observed that resident #003's health had declined and notified a staff nurse to call the physician, indicated an order for an identified antibiotic to address the discharge.

Review of the physician's orders dated twelve days after resident #003 was first noted to have a specified symptom indicated an order for two types of identified diagnostic tests to query for other infections.

A review of resident #003's identified diagnostic test results dated thirteen days after they were first noted to have a specified symptom showed that resident #003 had an identified infection in two other identified parts of their body. Review of their other diagnostic test which was also completed thirteen days later showed the results were negative.

Review of the physician's orders dated fourteen days after resident #003 was first noted to have a symptom indicated an order for a specified antibiotic to address the infection in the two other parts of their body.

In an interview, DOC #100 acknowledged that following resident #003's multiple negative results for an identified disease of public health significance, immediate action was not taken to identify and treat the underlying cause of the symptom for resident #003. DOC #100 acknowledged that resident #003 was neglected as they went untreated for their infections for fourteen days.

This non-compliance is additional evidence to the Compliance Order (CO) #002, issued under s. 19 (1)., during inspection # 2019_766500_0032 (A2) dated June 12, 2020. This non-compliance was issued as a result of the licensee failing to protect the resident from neglect. [s. 19. (1)]

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 has failed to ensure that a registered dietitian who was a member of the staff of the home completed a nutritional assessment for resident #003 when there was a significant change in the resident's health condition.

The MLTC received a complaint regarding neglect of resident #003's food and fluid intake.

Review of resident #003's Nutrition Priority Screen indicated that resident #003 was at high nutritional risk. Resident #003 was to be closely monitored and their weight was to be followed up with monthly and as needed. The assessment further stated as per the food/fluid intake flow sheet, resident #003 had a good appetite and their intake was 75-100% for most meals and nourishment passes with an occasional intake of 50-75% at dinner. Fluid intake was 10 units a day.

a) Review of Policy # 03-01-01 titled Nutrition Care and Hydration Program Overview, dated July 2011 stated that a basic component of effective resident nutritional care includes completing nutritional assessments on each resident at the time of admission, quarterly and when there is a significant change in status, and re-assessing the care plans at a minimum quarterly and when resident's care needs change.

Review of the progress notes with an identified date indicated that resident #003 had a specified symptom and was placed on isolation precautions. The local public health unit

declared the home in outbreak the following day.

In an interview, PSW #117 stated that when the home went into outbreak, resident #003 was always displaying a symptom and had a decline in their food and fluid intake. PSW #117 stated that they had brought the issue up to the registered nursing staff. PSW #117 stated that the nursing staff kept instructing them to encourage the resident to eat and provide fluids. One week after informing the registered nursing staff, PSW #117 informed ED #101 who then called in the complainant to assist in feeding resident #003.

In an interview, RPN #143 stated that resident #003 had not eaten for a few days and appeared to have lost weight when the complainant visited the resident on an identified date.

Review of Point of Care documentation indicated that resident #003's food intake decreased between an identified 11-day period. Resident #003 refused or did not have their snacks during this time period, and had reduced intake or refused during food for some meals. Other meals during this time period were missing documentation.

In an interview, PSW #145 stated that resident #003 had refused meals from them on two identified dates during this 11-day period, and that they had informed the nurse on duty. Review of the daily schedule identified the nurse on duty to be RPN #148. RPN #148 could not be contacted for an interview.

In an interview, RPN #143 stated that the home's process that was to be followed in the case that a resident is not eating, or there is a change/decline in their food/fluid intake is to complete an assessment, make a referral to the dietitian and notify the physician and substitute decision maker (SDM).

b) Review of resident #003's written plan of care indicated to encourage consumption of fluids at meals, between meals and medication pass so resident meets daily fluid target of an identified number of units (125ml cups) of fluid per day.

Review of Policy # 03-01-011 titled Hydration program, dated July 2011, reviewed January 2014 stated that if fluid intake remains low and/or below 50% for 3 consecutive days- referral to the registered dietitian is to be completed. A referral to the home's registered dietitian must be completed when a resident has fluid intake below their established goal for several days or residents altered fluid intake from their usual pattern. -The dietitian will complete a nutritional assessment

-A care plan addressing hydration status shall be developed and documented.

Review of Point of Care documentation indicated that resident #003's fluid intake decreased between a three-day period and a subsequent four-day period in the same identified month as when they had decreased food intake. Resident #003 was not meeting their daily fluid target identified in their written plan of care during these identified times.

Review of resident #003's medical records did not show that a referral to the dietitian had been made or that the MD had been informed in relation to resident #003's decreased food and fluid intake. A dietitian referral and assessment were not completed until 14 days after the end of the 11-day period of decreased food intake, and 15 days after the period in which they had decreased fluid intake. The assessment was completed as a result of the SDM's request to change a different part of the plan of care related to food for resident #003.

In an interview, RPN #143 acknowledged that a referral to and assessment by the dietitian were not completed for resident #003 when they experienced a significant change in their condition including a decline in their food and fluid intake during the identified month.

This non-compliance is additional evidence to the Compliance Order (CO) #001, issued under s. 26. (4) (a), during inspection #2020_766500_0007 dated September 18, 2020. This non-compliance was issued as a result of the licensee failing to ensure that a registered dietitian who was a member of the staff of the home completed nutritional assessments when there were significant changes in residents' health conditions. [s. 26. (4) (a)]

Issued on this 10th day of November, 2020

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

Original report signed by the inspector.