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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 19, 2019	2019_790730_0036	022558-19	Complaint

Licensee/Titulaire de permis

The Corporation of the City of St. Thomas
545 Talbot Street ST. THOMAS ON N5P 3V7

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

Valleyview Home
350 Burwell Road ST. THOMAS ON N5P 0A3

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

CHRISTINA LEGOUFFE (730), MEAGAN MCGREGOR (721)

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): December 3, 4, 5, and 6, 2019.

The following complaint inspection was completed:
Complaint Log #022558-19/ IL-72368-LO related to the prevention of abuse and neglect, continence care, nutrition and hydration, and responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Behavioural Services Ontario (BSO) lead, the Food Service Director (FSD), a Registered Dietitian (RD), a Dietary Aide, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The inspectors also observed resident rooms and common areas, observed meal service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed polices and procedures of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A) The Ministry of Long-Term Care (MOLTC) received a complaint, on a specified date, which included concerns related to nutrition and continence care for resident #001.

Inspectors #721 and #730 observed resident #001 eating lunch in the dining room on three consecutive dates. On all three occasions resident #001 was observed to have been served food that was a specified texture.

A review of resident #001's clinical record in Point Click Care (PCC) showed a diet order for a texture type which was different from what inspectors #721 and #730 had observed served to resident #001.

A review of resident #001's Annual Minimum Data Set (MDS) Assessment in PCC, completed on a specified date, showed "none of the above" under "Section K1: Oral Problems" and it was not indicated that they had a modified diet under "Section K5: Nutritional Approaches."

A review of resident #001's plan of care in PCC showed they were to receive a specified diet type and did not include any interventions related to having a modified texture diet.

During an interview, when asked who was responsible for serving residents their food, PSW #104 stated that dietary staff plated the food and then PSW staff served the food to residents. When asked how they knew what texture type a resident required, PSW #104 said that if a resident required a texture modified diet this was indicated on the sheet of paper the PSWs used to write down resident's food orders. They also said that dietary staff had this information on the computer located within the servery. PSW #104 told inspector #721 that resident #001 was on a texture modified diet.

During an interview, when asked how they knew what texture type a resident required, Dietary Aide #106 stated they looked at the resident's diet profile on the computer or the binder located within the servery. Dietary Aide #106 showed inspector #721 resident #001's diet profile on the computer in the servery, which indicated that they were on a regular, [as needed] specified modified texture type.

During an interview, Registered Dietitian (RD) #109 told inspector #721 that an RD or physician in the home determined what texture type a resident should be on and wrote diet orders. When asked where information regarding a resident's texture requirements would be documented in their plan of care, RD #109 stated it would be written under the care plan section in PCC. RD #109 said that if there was a change to a resident's texture type they would update the diet order and care plan in PCC. They said the diet profile in the home's nutrition management services program would also be updated and they would also document the changes on a communication sheet to let the Food Service Director (FSD) know. When asked what resident #001's food texture requirements were, RD #109 stated that they had recently completed a nutritional assessment for resident #001, on a recent specified date, and that they wore dentures and required a regular texture type.

A review of resident #001's assessments section in PCC showed a Nutrition/Hydration Risk Identification Tool completed on a specified date, which did not indicate they required a modified texture.

During an interview, when asked how staff knew what texture type a resident required, FSD #111 stated it was indicated on the resident's profile in the home's nutrition management services program on the computers in the servery. When asked what process would be followed if there was a change to a resident's texture type, FSD #111 said the RD updated the diet order in PCC first and then it would be updated in the home's nutrition management services program. When asked if they expected the

resident’s texture type in the nutrition management services program to be the same as the texture type in the diet order and care plan in PCC, they stated it should be. FSD #111 and inspector #721 reviewed resident #001’s diet profile in the nutrition management services program, which showed that they were on a regular, [as needed] modified texture type.

During an interview, when asked where a resident’s texture type would be indicated in their plan of care, Director of Care (DOC) #101 stated it would be on the care plan in PCC. DOC #101 said that PSW staff were responsible for checking that a resident received the appropriate food texture and that they would refer to a list generated from the dietary department to find out what a resident’s texture needs were. When asked who could make changes to a resident’s texture type, DOC #101 stated that the RD or physician could make the changes. DOC #101 said that registered nursing staff could downgrade a resident’s texture at any time for safety issues without a formal nutrition assessment, but that they would expect for the RD to follow-up on the change. When asked if they would expect the texture type indicated in a resident’s diet order and care plan in PCC to be the same as the texture type indicated in the nutrition management services program, DOC #101 said absolutely. When asked if they would expect a resident who required a specified modified texture, as needed, to have this indicated in their diet order and care plan in PCC, DOC #101 stated yes.

A review of the Nutrition and Hydration section of the homes Resident Care and Services policy showed the following:

-Subject: Overview of Program, Policy No. RC&S 12-1, stated in part that the goals of the Nutrition and Hydration program were "to ensure that the daily needs of the residents with respect to nutrition and hydration are respected and met consistently” and that “Valleyview Home shall ensure that all residents are provided with food and fluids that are safe, adequate in quantity, texture and diet specific for the individual resident, nutritious and varied.”

-Subject: Role of the RN/RPN, Policy No. RC&S 12-5, stated in part that the roles and responsibilities of the RN/RPN were to "collaborate with the interdisciplinary team in the assessment processes on admission, quarterly, with any significant change and at any other time a concern related to nutrition and hydration arises", "implement the plan of care consistently", "follow up on identified risks and situations and evaluate outcomes" and "refer to dietician as required."

-Subject: Feeding Residents, Policy No. RC&S 12-15, stated in part that "texture modification shall be provided after a nutritional assessment."

The licensee failed to ensure that the written plan of care in place for resident #001 set out clear directions to staff related to their food texture needs. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care, related to nutrition and hydration was documented.

The Ministry of Long-Term Care (MOLTC) received a complaint on a specified date, which included concerns related to nutrition, for resident #001.

A) During an interview, when asked what the home's process was for monitoring and documenting a resident's food intake, Personal Support Worker (PSW) #104 said that PSW staff monitored residents food intake at meals and documented information related to food intake on Point of Care (POC). PSW #104 stated that if they were busy and could not document then they would share food intake information with registered staff and they would document this information on Point Click Care (PCC).

A review of a reported titled "Documentation Survey Report v2" for resident #001, for specified dates, showed the following:

- "Oral Nutritional Status" scheduled daily between 0600 and 1400 hours which included questions about chewing problems, complaints about the taste of foods, mouth pain and complaints of hunger, was not documented on day shift on seven of 30 days in one month, and five of five days in the following month.
- "Amount Eaten" scheduled daily at 0815 and 1215 hours which included a question about what percentage of the meal was eaten, was not documented at 0815 hours on two of 30 days and at 1215 hours on seven of 30 days in one month, and at 0815 or 1215 hours on three of five days in the following month.
- "Eating" scheduled daily at 0815 and 1215 hours which included questions about self performance and support provided with eating and drinking, was not documented at 0815 hours on three of 30 days and at 1215 hours on seven of 30 days in one month, and at 0815 or 1215 hours on three of five days in the following month.
- "Oral/Dental Status" scheduled daily at 0700 and 1930 hours which included questions about denture care completed and whether debris was present in the mouth at bed time, was not documented at 0700 hours on six of 30 days and at 1930 hours on two of 30 days in one month, and at 0700 hours on four of five days in the following month.

A review of resident #001's progress notes section in PCC did not show any documented progress notes related to their food intake on the identified dates when documentation was not completed on POC.

During an interview, when asked where information related to a resident's food intake would be documented, Registered Dietitian (RD) #109 stated this was documented on POC. RD #109 said they reviewed the look back report for tasks related to food intake under the reports section in PCC to find documented information on a resident's food intake. RD #109 and inspector #721 reviewed the look back report for resident #001 for tasks related to food intake from the 14 days prior to this date. RD #109 said there was no documentation completed on several days during this 14 day period and that because food intake information was not documented, which made it hard for them to assess the resident.

B) During the inspection residents #003 and #004 were identified by a Dietary Aide as having specific needs related to food intake.

A review of a report titled "Documentation Survey Report v2" for resident #003, for specified dates, showed the following:
- "Oral Nutritional Status" scheduled daily between 0600 and 1400 hours, was not documented on day shift on seven of 30 days in one month, and four of five days in the following month.
- "Amount Eaten" scheduled daily at 0815 and 1215 hours, was not documented at 0815 hours on one of 30 days and at 1215 hours on five of 30 days in one month, and at 0815 or 1215 hours on three of five days in the following month.
- "Eating" scheduled daily at 0815 and 1215 hours, was not documented at 0815 hours on one of 30 days and at 1215 hours on four of 30 days in one month, and at 0815 or 1215 hours on three of five days in the following month.
- "Oral/Dental Status" scheduled daily at 0700 and 1930 hours, was not documented at 0700 hours on three of 30 days in one month and at 0700 hours on three of five days in the following month.

A review of a reported titled "Documentation Survey Report v2" for resident #004, for specified dates, showed the following:
- "Oral Nutritional Status" scheduled daily between 0600 and 1400 hours, was not documented on day shift on seven of 30 days in one month, and four of five days in the following month.

- “Amount Eaten” scheduled daily at 0815 and 1215 hours, was not documented at 0815 hours on 1 of 30 days and at 1215 hours on 7 of 30 days in one month, and at 0815 or 1215 hours on 3 of 5 days in the following month.
- “Eating” scheduled daily at 0815 and 1215 hours, was not documented at 0815 hours on two of 30 days and at 1215 hours on six of 30 days in one month, and at 0815 or 1215 hours on three of five days in the following month.
- “Oral/Dental Status” scheduled daily at 0700 and 1930 hours, was not documented at 0700 hours on four of 30 days in one month, and at 0700 hours on four of five days in the following month.

During an interview, when asked where information regarding a resident’s food intake was expected to be documented, Director of Care (DOC) #101 stated it was expected to be documented in POC by PSW staff. DOC #101 said that if PSWs were not able to complete documentation for tasks on POC that they expected they would verbally communicate this to registered staff who would document this information in a progress note on PCC. When asked how the RD was able to monitor and assess a resident’s food intake if this information had not been documented, DOC #101 said they would not be able to complete an accurate assessment based on documentation, in which case, they would talk to staff. When asked if staff had completed documentation in November and December 2019 for the identified tasks related to food intake for resident’s #001, #003 and #004, DOC #101 said they were made aware the week prior that this documentation was not completed on specific shifts and that they were taking action to address the issue.

A review of the Nutrition and Hydration section of the homes Resident Care and Services policy showed the following:
- Subject: Feeding Residents, Policy No. RC&S 12-15, stated in part that "difficulties eating or decreased appetite should be reported to the Registered Staff" and staff should "document intake on POC flow records".
- Intake and Output Monitoring, Policy No. RC&S 12-20, stated in part that "all residents require daily monitoring of their food and fluid intake to assess if they are at risk for dehydration or malnutrition. Food and fluid intake for all meals and snacks, as well as nutritional supplementation given outside of medication passes, is recorded in the resident's electronic flow record (POC)".

The licensee failed to ensure that the provisions, outcomes and effectiveness of the care set out in the plan of care related to food intake was documented for resident’s #001, #003 and #004 on multiple occurrences in two consecutive months. [s. 6. (9)]

3. The licensee has failed to ensure that the provision of care, related to continence care, was documented.

The Ministry of Long-Term Care (MOLTC) received a complaint on a specified date, which included concerns related to continence care for resident #001.

A) A review of resident #001's plan of care in Point Click Care (PCC) included a focus related to toileting with specific interventions.

Review of a report titled “Documentation Survey Report v2” for resident #001, for specified dates, included documentation on every shift for the intervention/task “Toilet Use.” There was no documentation on 13 out of 90 shifts (14 per cent) for one month and no documentation on four out of 12 shifts (33 per cent) for the following month.

During an interview, PSW #108, said that care was documented on Point of Care (POC). They said that the expectation in the home was that toileting was documented every shift, unless the resident was on a toileting routine. PSW #108 said that they were familiar with resident #001, and that they required specified assistance for toileting. They also told the inspector that they felt that the home was able to meet resident #001’s needs related to continence care.

During an interview, Director of Care (DOC) #101 said that the expectation in the home was that continence care would be documented on every shift. Upon review of the “Documentation Survey Report v2” for resident #001’s continence care for the specified dates, the DOC said that it did not meet the home’s expectation for documentation. The DOC told inspector #730 that they had been made aware of the missing documentation and that the home planned to have a meeting with the staff who worked on the shifts where the documentation was missed to discuss the home’s expectations with them.

B) During an interview with DOC #101, resident #005 was identified as a resident who required assistance with continence care.

A review of resident #005’s plan of care in Point Click Care (PCC), included a focus related to toileting with specified interventions.

Review of a report from PCC titled "Documentation Survey Report v2," for specified dates, for resident #005, included every shift documentation of “Toilet Use.” There was

no documentation on six of 90 shifts (seven per cent) in one month.

During an interview with PSW #110, they said that resident #005 required assistance with continence care. They said that they felt that the home was able to meet resident #005's needs related to continence care. After reviewing the documentation for resident #005's continence care for the specified dates, the PSW said that the documentation would not be considered complete, as they needed to document on every shift.

C) During an interview with DOC #101, resident #006 was identified as a resident who required assistance with continence care.

A review of resident #006's plan of care in Point Click Care (PCC), included a focus related to toileting with specified interventions.

Review of a report from PCC titled "Documentation Survey Report v2," for specified dates for resident #006, included every shift documentation of "Toilet Use." There was no documentation on six of 90 shifts (seven per cent) in one month.

During an interview with PSW #110, they said that resident #006 required assistance for continence care. They said that they felt that the home was able to meet resident #006's needs related to continence care. After reviewing the documentation for resident #006's continence care for the specified dates, the PSW said that the documentation was not complete.

The licensee has failed to ensure that provision of the care set out in the plan of care, related to toileting, for residents #001, #005, and #006 was documented. [s. 6. (9) 1.]

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 plan of care provides clear direction for dietary needs and that the care provided to residents is documented, to be implemented voluntarily.

Issued on this 24th day of December, 2019

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

Original report signed by the inspector.