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

Division de la responsabilisation et de la performance du système de santé
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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
Feb 19, 2013	2013_208141_0007	H-002239-12	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

SHARLEE MCNALLY (141), ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 24, 28, 29, 30, 31, and February 1, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Directors of Care (ADOC), Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Registered Dietitian, Food Service Manager, Food Service Supervisor, Dietary Staff and residents

During the course of the inspection, the inspector(s) reviewed resident's records, home's investigation notes, policies and procedures, observed noon meal service in two home areas.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (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 :

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1. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at a time when the resident's care needs changed s. 6 (10) (b)
The licensee did not ensure an identified resident was reassessed and the written plan of care was reviewed and revised when there was a change in resident nutritional care needs. The plan of care did not include an assessment identifying risk of dehydration. A review of resident's fluid intake record for October and November 2012 indicated the resident consumed less than 1500 ml fluids/day for nine consecutive days in October and five consecutive days in November 2012. The written plan of care did not include changes in the resident hydration needs including fluid intake and monitoring needs.
The plan of care for the identified resident was not reviewed and revised when resident had a significant weight loss. A progress note in November, 2012 identified that the resident had a significant weight loss over six months and the resident was below established goal weight range and had a low Body Mass Index (BMI). However, the plan of care for the same date stated there was potential for weight loss. The written plan of care was not revised and did not include an assessment related to weight loss and the evaluation of resident's poor oral intake. The registered dietitian confirmed that the plan of care did not identify weight changes, and the interventions to meet resident's nutritional needs. [s. 6. (10) (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 residents are reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: 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:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the plan, policy, protocol, procedures, strategy, or system related to hydration was complied with. O. Reg.79/10, s. 8 (1) (b)
The home's Hydration Policy (FS-04-01-18) stated the registered staff were to review the food and fluid intake sheets to identify residents consuming less than 1500 ml per day for two or more consecutive days. Those identified at less than 1500 ml of daily fluid intake for more than 2 consecutive days were referred to the dietitian.
A review of food and fluid intake record of an identified resident indicated that the resident received less than 1000 ml a day for nine consecutive days in October, 2012 and consumed less than 1250 ml fluids/day for five consecutive days in November, 2012. There was no documentation to support that a referral was made to the dietitian in relation to insufficient fluid consumption for more than two consecutive days. The policy was not complied with in relation to a referral was not made to the dietitian. The Home's dietitian confirmed that a referral was not made by the registered staff. [s. 8. (1)]

2. The licensee did not ensure where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with. During the inspection period the compliance inspector on a identified day observed the dining room door located in the Willow home area was unlocked after the lunch meal was completed. There were no nursing staff in the area. A small white tablet in a paper medication cup was noted on a table marked with an identified resident's name. Review of the resident's Medication Administration Records (MARs) identified the resident was to receive a specific medication at the noon meal and the MAR had been signed to indicate the medication had been administered. The MARs did not identify the resident was able to self medicate. Review of the resident's medication supply confirmed the type of pill found and the package for this date was not found in the medication cart. The home's policy and procedure "Medication Administration Rounds" stated administer medications to resident ensuring the resident swallows them, unless there is a physician's order to leave medication at the bedside, and after administration initial the square on the MARS that corresponds to to the date and time of the medication administered. Another compliance inspector confirmed the medication had been left in the dining room. [s. 8. (1) (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 where the Act or 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 ensures that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: 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. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that an interdisciplinary assessment of hydration status and any risk relating to hydration was completed with respect to the following: O.Reg.79/10, s. 26(3) 14
An interdisciplinary assessment of an identified resident's hydration status and risks related to hydration was not completed. The triggered dehydration and fluid maintenance Resident Assessment Protocol (RAP) summary completed in October, 2012 did not include assessment of the resident's current fluid intake and risk related to hydration. Interview with the dietitian confirmed that an interdisciplinary assessment and care planning of resident's hydration status and also risk related to hydration did not occur for the resident. Resident was identified at high nutritional risk for dehydration and poor oral intake. [s. 26. (3) 14.]

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 an interdisciplinary assessment of each resident's hydration status and any risks relating to hydration is completed, to be implemented voluntarily.

WN #4: 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 did not ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. An identified resident had a physician order initiated in October, 2012 for drops to be instilled up to 4 times daily as needed. The resident's MAR record for November 2012 indicated the order was changed to 4 times daily and the resident received the drops as per this direction for 3 weeks. The progress notes stated the order on MAR sheet was changed to reflect drops will be given 4 times daily. A RPN confirmed to the DOC they had changed the order on the MAR. There was no documented order by the physician to change the direction of the medication originally prescribed. The DOC confirmed the order in the MAR should not have been changed without a physician order. [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 resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. A registered nursing staff caring for an identified resident in November, 2012 stated she had administered a medication to the resident for discomfort. The documentation on the MARs did not identify the medication had been administered to this resident. Another resident's MARs identified that they had received the identified medication for discomfort. The registered nursing staff, who administered the medication, confirmed they had documented the medication administered to the first identified resident in the 2nd identified resident's MAR record. [s. 30. (2)]

Issued on this 20th day of February, 2013

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