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

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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
Feb 12, 2015	2015_288549_0003	O-000760-14	Complaint

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE BOURGET
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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

RENA BOWEN (549)

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): January 26 and 27, 2015

During the course of the inspection, the inspector(s) spoke with several Personal Support Workers, a Registered Practical Nurse, the RAI- Coordinator, the Food Services Manager, the Registered Dietitian, the Director of Care and the Administrator. The inspector also reviewed the specific resident's health care file, the fluid and food intake documentation and the home's laboratory request binder.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with a change of 5 % of body weight, or more over one month are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Inspector #549 reviewed Resident #1's documented monthly weights which are kept in the electronic documentation system Point Click Care. Resident #1 had a body weight on a specific date of 90.6kg which is a -9.9 % change in comparison to the previous weight.

On January 27, 2015 during an interview with the Registered Dietitian and the Food Services Manager it was confirmed with Inspector #549 that Resident #1 was not assessed using an interdisciplinary approach, and no actions were taken and outcomes evaluated related to the resident's significant weight loss.

The Registered Dietitian stated to Inspector #549 on January 27, 2015 that the Point Click Care electronic system is programmed to alert the Registered Dietitian when there is a change in the residents' weight by producing a report. The Registered Dietitian stated the system did not populate an alert for Resident #1's weight change so she was not aware of the weight loss.

Inspector #549 reviewed the individual electronic file for Resident #1 on January 26, 2015 and did see an alert for Resident #1's weight change for the specific month.

During the interview with Inspector #549 on January 27, 2015, the Dietitian stated that she did not look at the individual electronic weight documentation for Resident #1; her practice at the time was to look at the alert report.

The Dietitian also stated to Inspector #549 that her present practice is to print off all of the resident's weights for the month and review them for any weight changes. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 141. Licensee to stay in contact

Specifically failed to comply with the following:

s. 141. (1) Every licensee of a long-term care home shall maintain contact with a resident who is on a medical absence or psychiatric absence or with the resident's health care provider in order to determine when the resident will be returning to the home. O. Reg. 79/10, s. 141 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that contact was maintained with the health care provider when the resident was on medical leave, to determine the return date to the home.

Resident #1 was admitted to the hospital on a specific date due to a decline in health and at the request of the Power of Attorney for Care.

Resident #1's electronic progress notes were reviewed by Inspector #549 for the specific period.

There are several progress notes during this time period stating that Resident #1 "remains in hospital", but no indication in the progress notes that the hospital was actually called to determine the return date to the home.

RPN #102 stated during an interview with Inspector #549 that she could not recall if she had contacted the hospital during the specific admission period.

During a discussion with Inspector #549 on January 27, 2015, the DOC was not able to confirm that the hospital was contacted by the home during Resident #1's admission period.

The DOC confirmed that she did not maintain contact with the hospital during Resident #1's admission period. The home was informed on a specific date by Resident #1's Power of Care that the resident had passed away in the hospital. [s. 141. (1)]

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Issued on this 12th day of February, 2015

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

Original report signed by the inspector.