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
Jul 24, 2020	2020_779641_0020	013516-20, 014543-20	Complaint

Licensee/Titulaire de permis

Carveth Nursing Home Limited
375 James Street GANANOQUE ON K7G 2Z1

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

Carveth Care Centre
375 James Street GANANOQUE ON K7G 2Z1

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

CATHI KERR (641), HEATH HEFFERNAN (622)

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 17, 20, 21, 22, 2020.

This inspection was conducted in relation to intake log #013516-20, a complaint related to COVID-19 related infection control practices; and intake log #014543-20, a complaint related to resident care concerns.

During the course of the inspection, the inspector(s) spoke with the President/Director, the Director of Care, the Acting Director of Care, Assistant Director of Care, Dietary Supervisor, Registered Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family and residents.
During the course of the inspection, the Inspectors observed resident care and reviewed resident health care records; and policies and procedures related to nutrition and hydration, and infection prevention and control practices relevant to COVID-19.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

The licensee has failed to ensure that resident #001's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A review of the electronic progress notes on Point Click Care, indicated that beginning on a specified date, resident #001 had experienced a change in their health condition. The progress notes indicated that the Substitute Decision Maker (SDM) for resident #001 was notified by Registered Nurse (RN) #103 of the resident's declining condition seventeen days later. No other progress notes had been documented between those specified dates that would indicate that resident #001's SDM had been notified of their declining condition. After the SDM had been notified, resident #001 continued to decline with a significant weight loss noted. The SDM was in regular contact with the long-term care home and requested that resident #001 be transferred to hospital fourteen days after initially being contacted.

During an interview with inspector #622 on July 21, 2020, Registered Dietitian (RD) #105 stated that they would normally notify the resident's SDM when they had received a dietitian referral. RD #105 stated that they had not received a dietary referral for resident #001's declining condition in the specified month, and therefore, had not notified the SDM.

During separate interviews with inspector #622 on July 22, 2020, Registered Nurse (RN) #103 stated that for four weeks in the specified months, resident #001 had a health decline. RN #103 stated resident #001's SDM was notified of the residents declining condition for the first time on the specified date, seventeen days after it was initially noted that the resident had symptoms.

Director of Care #101 stated that since resident #001 had a decline in health condition beginning on a specified date and their SDM was not notified until seventeen days later, resident #001's SDM was not given an opportunity to participate fully in the development and implementation of the resident's plan of care at that time. [s. 6. (5)]

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 resident, the resident's substitute decision-maker, and any other persons designated by the resident are given an opportunity to participate fully in the development and implementation of the resident's plan of care, 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 :

The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any, Nutrition Care and Hydration Program policy, the licensee is required to ensure that the policy is complied with.

According to O. Reg. 79/10, s. 68 (2). (a).
Every licensee of a long-term care home shall ensure that the programs include, 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 the nutrition care and dietary services and hydration.

During the inspection, on July 22, 2020, Dietary Supervisor #104 stated that the licensee’s dietary policy and procedure manual, which included Chapter #5 - Dietitian

Consultant Referral was part of the licensee's Nutrition Care and Hydration Program.

A review of the licensee's dietary policy and procedure manual, Chapter #5 - Dietitian Consultant Referral, dated revised June 18, 2019 stated that when a nutritional concern arises as a result of a resident's medical condition, a change in a resident's medical condition or as a result of a resident's quarterly assessment, Registered Nursing staff and/or the Food Services Manager will use the Registered Dietitian referral form to notify the Consultant Dietitian of any of the following resident conditions:
- Consistently poor food intake (leaving 25% or more at most meals).
- Inadequate fluid intake for 72 hours (less than 1500 ml/24 hours).
- Signs or symptoms of dehydration.
- Chewing or swallowing difficulties.
- Nausea and vomiting.

A review of the electronic progress notes on Point Click Care, indicated that beginning on a specified date, resident #001 had a significant health decline and decline in dietary intake. Fifteen days later, Registered Dietitian (RD) #105 documented that resident #001 had a significant health decline.

On a specified date , it was noted that resident #001 had lost a significant amount of weight in one month. The resident was transferred to hospital on a specified date, after a request from the resident's substitute decision maker. There were no progress notes to indicate that registered staff or the Dietary Supervisor had completed a dietitian's referral from the time of onset of symptoms to when the resident was transferred to the hospital.

During an interview with inspector #622 on July 21, 2020, RD #105 stated that they visit the long-term care home weekly, and they receive written dietitian referrals for significant changes in the resident's health including, swallowing and/or chewing difficulties. RD #105 stated that resident weight changes are usually received verbally from the Dietary Supervisor. RD #105 stated that they had not received any dietitian referrals for resident #001's health decline between the specified dates. RD #105 stated they became aware of resident #001's decline when it appeared on the resident dashboard on Point Click Care fifteen days after onset. RD #105 stated they were informed by the Dietary Supervisor #104 the day prior to resident #001 being sent to the hospital, that the resident had lost a significant amount of weight during the specified month.

Therefore, the licensee's dietary policy and procedure manual, Chapter #5 - Dietitian Consultant Referral was not complied with, when RD #105 did not receive a dietitian's

referral for resident #001's change in condition during the specified period. [s. 8. (1) (a),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 that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place a Nutrition Care and Hydration Program policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

Issued on this 6th day of August, 2020

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

Original report signed by the inspector.