Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 26, 27, Aug 17, 31, 2011	2011_066107_0005	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - BRAMPTON WOODS
9257 Goreway Drive, BRAMPTON, ON, L6P-0N5

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

MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Nurse Managers, Resident Assessment Instrument (RAI) Coordinator, ARAMARK Food Service Manager, Food Service Supervisor, Registered Dietitian, Nurse Practitioner, nursing staff on the first, second and third floors, dietary staff, residents, and reception staff, in relation to complaint inspection H-00983-11

During the course of the inspection, the inspector(s) Reviewed an identified resident's clinical health record, reviewed the storage areas of the home, and reviewed relevant policies and procedures.

The following Inspection Protocols were used in part or in whole during this inspection:

Nutrition and Hydration

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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
(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).

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).

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.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits sayants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(5)]
The licensee did not ensure that an identified resident's substitute decision maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care. The resident had an upper respiratory tract infection (URI) with antibiotics initiated in 2010. Documentation does not reflect that the substitute decision maker was informed of the change in condition.

2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(9)1,2]
The licensee did not ensure that the provision of care set out in the plan of care and the outcomes of the care set out in the plan of care were documented.
A Nurse Practitioner order for a treatment was written in 2011, and was administered to the resident (as per staff interview), however, documentation does not reflect that the treatment was initiated. The Medication Administration Record (MAR) is not signed to reflect the treatment was provided and progress notes do not support that the treatment was initiated.
Documentation in the progress notes in 2011 identifies concerns with lack of supplies for the administration of a treatment, however, the outcome of the concerns was not documented. Registered staff interviewed stated alternative supplies were used in the administration of the treatment, however, this was not documented.

The licensee did not ensure the provision of the care set out in the plan of care for an identified resident was documented in relation to turning and repositioning for two days in one month of 2011. The plan of care requires the resident to be repositioned every hour, however, the 'Turning and Repositioning Record' for two days is signed but does not indicate the resident was repositioned during those times. Staff interview could not determine if the care was provided and not documented or if it was related to a documentation omission.

Documentation on an identified resident's clinical record (PSW flow sheets, wound treatment records) does not consistently identify the date the care was provided. Many of the documents were not dated with the month or year and it was not clear when the documentation records were from. The management team was unable to locate PSW flow sheets for the month of December 2010 and part of October 2010.

3. [LTCHA, 2007, S.O. 2007, c.8, s. 6 (1) (c)]
The written plan of care for an identified resident did not provide clear direction to staff who provide direct care to the resident. The plan of care directs staff that the resident does not require bed rails and also directs staff to provide two bed rail for safety. Staff interviewed confirm the plan is not clear in relation to the use of bed rails for this resident.

4. [LTCHA, 2007, S.O. 2007, c. 8, s. 6 (10) (b)]
An identified resident was not reassessed and the plan of care reviewed and revised when the resident's care needs changed. The identified resident went from consuming 17% of meals poorly (50% or less) in one month in 2010, to 57% of meals taken poorly for the next month and a half. The resident also had a decrease in hydration from 16% of the time taking < 1000ml of fluids daily to 79%. The resident's target fluid intake was 1500ml/day (as per the plan of care). An assessment of the decrease in food and fluid intake was not completed by the interdisciplinary team. Nursing and dietary staff interviewed confirmed that the poor intake was not identified or assessed despite the change in status of the resident.
At the 2010 RAI-MDS assessment completed by the Food Services Supervisor, there was no mention of the reduction in food and fluid intake over the quarter and the plan of care was not revised to include strategies to address the poor nutritional intake, nor a referral to the Registered Dietitian. Progress notes do not identify the poor intake until the beginning of 2011, however, food and fluid intake records identify a decline beginning two months prior in 2010. Action was not taken until 2011, when the resident was diagnosed with dehydration.

The plan of care for an identified resident was not revised when the resident's care needs changed. The resident had a decline in condition, however, the plan was not revised to reflect the decline in condition.
1. The Restorative Eating plan of care for 2010 and 2011 states that the staff are to put jam on the bread/toast and give it to the resident in their hand. The resident has been receiving a pureed menu since 2010.
2. The Eating section of the plan of care dated 2011 states that staff have to cut up the resident's meat, however, the resident has been receiving a pureed menu since 2010.
3. The Eating section of the plan of care dated 2011 states that the resident prefers pills crushed and mixed in their food and drink. The resident had a decline in food and fluid intake (57% and 56% of meals taken poorly (1/2 or less), however, the plan of care was not revised to reflect the decline in intake at meals and the effect of placing medications into food and fluids when the resident is eating poorly.

4. The plan of care related to eating ability dated 2011 states the resident will at times need assistance with completing their meals with staff help and set up for cutting up food and opening containers, however, staff interview supports that the resident often required full assistance with eating. The plan of care was not revised to reflect the increased assistance required with eating.
5. The plan of care for the identified resident was not revised to reflect the resident's change in condition (Palliative status) and the effect of the palliative status on all other areas of the plan of care.

5. [LTCHA, 2007, S.O. 2007, c.8, s. 6 (10)(c)]
At the 2011 Resident Assessment Protocol (RAP) triggered for dehydration, the RAP identifies the resident does not drink sufficient fluids and that their fluid intake does not meet minimum recommended intake to maintain hydration. The plan was to continue with the current plan of care. The plan was not revised to include interventions to address the insufficient fluid intake. The resident's food and fluid intake records for one month reflect 79% of the time the resident is consuming less than 1000mL of fluids per day and the resident consumed less than 1500mL per day on 16/18 days from the first half of the next month. The resident's plan of care identified a goal for fluid intake of 1500mL per day, however, the plan of care was not revised when this goal was not achieved.

6. [LTCHA, 2007, S.O. 2007, c.8, s. 6(4)(a)]
Not all staff involved in the different aspects of care collaborated with each other in the assessment of an identified resident so that their assessments were integrated, consistent with and complemented each other.
At the 2010 Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment, the nursing staff member completing the coding portion of the assessment entered a weight that was different than the weight referenced by the Food Services Supervisor who completed the Resident Assessment Protocol (RAP) Summary. The weight the nursing staff member coded would represent a 15.1% significant weight loss over one month, however, the weight the Food Service Supervisor coded would represent a non-significant weight loss of 2.9% over one month. The Food Services Supervisor did not reference the significant weight loss identified in the coding or identify the inconsistencies between the weight recordings as part of the RAP summary assessment. The Food Services Supervisor stated there was no significant weight loss noted. The assessments are not consistent with each other.
In 2011, the same nursing staff member who entered the [redacted] RAI-MDS coding wrote a progress note identifying a significant weight loss of 10% over 6 months with a referral to the Registered Dietitian for assessment. Information on the weight monitoring forms taken by nursing staff are not consistent with a significant weight loss of 10% over 6 months for 2011 and are not consistent with a significant weight loss in 2010.
During interview with nursing and dietary staff, staff were unable to identify why the discrepancies in the assessments occurred.

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 with sections 6(1)(c),6(4)(a), 6(5), 6(9), and section 6(10)(b)(c) , 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 subsections:

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

Findings/Faits sayants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 8 (1)(b)]
The home's policy 'V3-710' related to a treatment was not followed by staff providing care to an identified resident in 2011. The policy identifies that the initiation of the treatment is to be documented in the progress notes, including time of insertion, site, size of the equipment used, solution used, flow rate, condition of site, resident's response, 24 hour intake and output, signature and status. The staff is to then assess resident every 30 minutes for the first hour, then a minimum of every two hours thereafter. Documentation in the progress notes did not include the above information.
2. The licensee of the home did not ensure that the Home's policy and procedure 'Hydration Management Program - V9-251' was complied with in relation to an identified resident and that the policy was consistent with the provision of fluids on the approved menu.
The Home's policy identifies that after 3 consecutive days of fluid consumption < 1500ml per day, a referral to the Registered Dietitian will be initiated immediately for residents with identified risks. Nursing is to immediately initiate interventions to increase fluid intake. Nursing is to continue to monitor for signs and symptoms of dehydration and document each shift until the resident's daily total fluid intake increases to 1500ml or more for 3 consecutive days. Registered Nursing staff is to notify the resident's substitute decision maker of the decrease in hydration, and nursing staff will document the outcome of nursing interventions in the progress notes and update the nursing care plan with new interventions. Registered staff discuss with the attending physician or delegate to do a medication review for any medication such as diuretics that may need to be held until the resident has adequate fluid intake. The Registered Dietitian is to reassess the fluid requirements and reviews/revises the nutritional care plan of any resident with a change in condition that may increase the resident's risk for dehydration. The Food Services Manager/Supervisor is to refer the resident to the Registered Dietitian for further assessment as necessary. The Physiotherapist/Occupational Therapist evaluates and advises the interdisciplinary team on seating/assistive devices to maximize independence/optimize intake at meals and nourishment passes.
An identified resident consumed less than 1500ml on all recorded days except one for three months in 2010 and one month in 2011. The Home's Hydration Management program was not initiated until after the resident was diagnosed with dehydration. The resident had a significant reduction in hydration in [redacted]2010, with nine consecutive days of fluid intake < 1000ml per day. All components of the Hydration Program listed above were not complied with for this resident after the reduction in hydration beginning in 2010.

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 with ensuring 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 plan, policy, protocol, procedure, strategy or syste, the licensee is required to ensure 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. 68. Nutrition care and hydration programs

Specifically failed to comply with the following subsections:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) 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 nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits sayants :

1. A system to evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration is not in place. [O.Reg. 79/10, s.68(2)(d)]
The system that monitors the intake of food and fluids for residents with identified risks related to nutrition and hydration does not allow for consistent evaluation of the intake. Discrepancies are noted between information recorded on the "Nutritional Intake Record" and information documented in the progress notes for the same meal. Six days in a 22 day period had examples of discrepancies between the amount of intake recorded on the Nutrition Intake Record and in the progress notes.

2. At an identified resident's Annual review in 2010, the Registered Dietitian initiated a nutrition intervention to be given daily for identified risks related to nutrition and hydration. The food and fluid records for five months do not include a location to record the intervention. Nursing and dietary staff interviewed were unable to identify from the documentation if the intervention was provided or consumed. An evaluation of the effectiveness of the intervention did not occur after it was initiated. It was unclear if the resident was receiving or consuming the nutrition intervention.

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 with ensuring there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, to be implemented voluntarily.

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 subsections:

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
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits sayants :

1. [O.Reg. 79/10, s.26(4)(a)(b)]
The Registered Dietitian, who is a member of the staff of the home, did not complete a nutritional assessment for an identified resident when there was a change in the resident's health condition and therefore, did not assess the resident's nutritional status, including risks related to nutrition care and hydration.
The resident had a significant reduction in food intake over a three month period in 2010 - 2011, and a significant reduction of hydration in 1.5 months in 2010, however, a referral to the Registered Dietitian did not occur until 2011.
The 2010 quarterly RAI-MDS assessment was completed by the Food Service Supervisor and the poor intake was not identified or referred to the Registered Dietitian for assessment.
In 2011 the resident returned from hospital with a diagnosis of dehydration and a change to the resident's diet order. A referral to the Registered Dietitian for assessment of the diet change was not initiated upon return from hospital.

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 with ensuring that a Registered Dietitian who is a member of the staff of the home, completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition and assesses the matters referred to in paragraphs 13 and 14 of subsection (3), to be implemented voluntarily.

Issued on this 12th day of September, 2011

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