



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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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
Mar 1, 2013	2013_190159_0008	H-000031- 13	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

NORTHRIDGE
496 POSTRIDGE DRIVE, OAKVILLE, ON, L6H-7A2

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

ASHA SEHGAL (159)

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): February 19, 20, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Dietitian, Registered Practical Nurse, Food Service Manager, nursing, dietary staff and residents.

During the course of the inspection, the inspector(s) observed meal service, reviewed medical records and plans of care for identified residents, reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:



Dining Observation

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care



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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. (11) When a resident is reassessed and the plan of care reviewed and revised,
- (a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
 - (b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :



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1. The licensee did not ensure that plan of care set out gives clear directions for the staff and others who provide direct care to the resident.[s. 6 (1) (c).
The plan of care for resident # 3 did not give clear direction to staff and others who provide direct care to the resident, as it did not include strategies for meeting resident's nutritional needs and interventions related to resident's refusal of meals. The resident was identified being severely underweight and low body mass index. The plan of care did not specified a personalized meal plan i.e menu, frequent feeding timings and food preferences.[6(1)(c)]
2. The licensee did not ensure that the plan of care for resident # 3 was revised as the care set out in the plan of care had not been effective and different approaches were considered.[s.6(11)(b)
The plan of care for resident #3 was not revised and different approaches considered when care set out in the plan of care had not been effective in relation to poor oral intake and refusal of breakfast and lunch meals most days. Staff interview and the review of daily food and fluid intake record confirmed that resident had been refusing meals (breakfast and lunch most days,(28/31 days in January 2013). Interview with the staff and documentation review confirms that resident does not come to the dining room for breakfast. The assessment completed by the registered dietitian December 2012 did not include an evaluation and effectiveness of strategies/interventions in relation to resident's poor oral intake, and refusing meals most days. The interventions in place were ineffective in meeting resident's nutritional needs. [s. 6. (11) (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 ensuring that plan of care sets out clear directions for the staff and others who provide direct care to the resident and the plan of care is revised, different approached are considered when care set out in the plan of care is not effective, 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).**
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Findings/Faits saillants :

1. The licensee did not ensure the plan , policy, protocol, procedures, strategy or system related to food and fluid intake monitoring was complied with for resident # 3. [s. 8 (1) (b).

The Minimum Data Set(MDS)Quarterly Review Assessment completed December 2012, the resident was identified as being at high nutritional risk due to poor food and fluid intake, leaves 25% or more of food uneaten, severely underweight, low Body Mass Index. A review of resident's food and fluid intake record for January and February 2013 indicated the resident had refused nine meals on three consecutive days in January 2013, and five consecutive meals over two days in February 2013. The home's policy " Food and Fluid intake Monitoring"(LTC-G-30) dated August 2012 stated that a referral to the registered dietitian will be initiated if a resident's food intake from meals is recorded as less than 50 %. The food and fluid intake record indicated the resident had refused nine meals on 3 consecutive days. There was no supportive documentation that resident's food intake was monitored and a referral was made to the registered dietitian for nutritional assessment. The policy was not complied with in relation referral to the registered dietitian.

Resident # 3 had a written physician order for nutritional supplement, Ensure Plus 125 ml three times a day, and also as needed. The home's policy "Food and Fluid intake Monitoring " (LTC-G-30) stated nutritional supplement will be recorded/signed on the Medical Administration Record (MARS) or on the paper intake monitoring tool/Point Of Care (POC) as ordered by the Physician/Nurse Practitioner/Registered Dietitian. Staff interview confirmed that resident had been receiving ensure plus 3 x a day and also PRN. However, review of MARS and interview with the Director of Care confirms that PRN supplement dispensed by the registered staff was not recorded on the MARS in accordance with home's policy. [s. 8. (1)]



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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 ensuring that the plan, policy, protocol, procedures, strategies and system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident is offered a minimum of three meals daily.[s.71((3)(a)]

The plan of care for resident # 3 had identified resident at high nutritional risk due to poor food and fluid intake. Staff interview, review of plan care and progress notes confirms that resident does not come to the dining room and sit at the table for meals. During the noon meal service the resident was observed wandering on the unit halls and not in the dining at the table. At approximately 1405 hours Staff interview confirmed that resident was not offered lunch. At 1420 hours after the inspector intervened, a personal support worker served resident 235 ml Ensure Plus nutritional supplement and a high fibre snack bar. A review of food and fluid intake record for January and February 2013 indicated that resident had refused breakfast and lunch meal most days. However, there was no documentation to support that the staff had offered resident a minimum of three meals daily. Resident # 3 was deemed high nutritional risk due to being severely underweight, poor oral intake. [s. 71. (3) (a)]

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 each resident is offered a minimum of three meals daily, to be implemented voluntarily.



WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that the home had a dining and snack service that include, at a minimum, providing residents with eating aids, assistive devices, personal assistance and encouragement required to safely eat, and drink as comfortably and independently as possible.

During the lunch meal service on a specified unit home area, residents at table # 1, 2, and 8, were observed who did not consumed their fluids, these resident required significant cueing and encouragement as specified in the plan of care. Staff did not make any attempts to encourage these residents to consume fluids. Unconsumed beverages were removed from these residents' tables.[s.73 (1)9] [s. 73.(1) 9.]

2 During the lunch meal service staff did not provide proper feeding techniques to assist residents with eating. The staff feeding an identified resident was not at eye level with resident, creating a barrier to monitoring the swallowing ability of the resident. Resident's plan of care states requires assistance for eating. The resident is total fed and should be in the upright feeding position (head needs tilting 90 degree forward for feeding). Resident was observed at the table sitting in a tilt chair, head down and fed by the staff, creating a risk of choking. [s. 73. (1) 10.]



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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 ensuring that the home has a dining and snack service that include providing residents personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible and that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

Issued on this 1st day of March, 2013

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

Asle Selvar