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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jan 7, 2014	2013_280541_0007	O-001221-13	Critical Incident System

Licensee/Titulaire de permis

PROVIDENCE CARE CENTRE
340 Union Street, KINGSTON, ON, K7L-5A2

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

PROVIDENCE MANOR
275 SYDENHAM STREET, KINGSTON, ON, K7K-1G7

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

AMBER MOASE (541)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 30, 2013 and January 3, 2014.

This inspection related to Critical Incident #C553-000017-13.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), a Registered Nurse, a Registered Dietitian and the Director of Care.

During the course of the inspection, the inspector(s) reviewed resident health care records including care plans, food and fluid intake sheets, progress notes and quarterly interdisciplinary assessments and observed meal service in dining rooms.

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

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 2007, c. 8, s. 6 (4).
(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).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA 2007 c.8 s.6(4)(b) in that the staff

and others involved in the different aspects of resident #1's care did not collaborate with each other in the development and implementation of the plan of care and the different aspects of care were not integrated and consistent with each other.

Resident #1 was not referred to the dietitian when he/she returned from the hospital with a respiratory infection and at risk of dehydration nor when he/she experienced a significant weight loss.

Resident #1's health care records indicate that on a specific date, resident #1 returned from the hospital with a respiratory infection after an incident at the home. Resident #1's discharge summary indicates he/she could easily become dehydrated and that oral(po) fluid intake needs to be strongly encouraged.

A review of resident # 1's health care record indicates there are no referrals to the dietitian from a specific date until time of discharge. There are no progress notes from the dietitian from a specific date until time of discharge. The dietitian was not referred to when resident #1 returned from hospital with a respiratory infection and at risk of dehydration. [s. 6. (4) (b)]

2. A review of nutritional assessments completed on two specific dates indicates resident #1 was identified as high nutritional risk due to low body weight.

A review of resident #1's weight records indicate that during a specific two month period, resident #1 had a weight loss of 3.4 kg (8.4%). Staff #107 confirmed that referrals are kept in resident health care records and assessments are documented either on the referral sheet or in the progress notes.

Resident #1's health care record was reviewed and no referral was sent to the dietitian regarding this weight loss. [s. 6. (4) (b)]

3. The "Dyshpagia Managment" policy states "the RN/RPN will initiate a referral form to the Clinical Dietitian noting the areas of concern relating to signs and symptoms of dysphagia".

On eight specific dates, the food and fluid flow sheets indicated resident #1 had a swallowing problem.

Upon review of resident #1's health care record, there were no referrals to the dietitian

during the time of these specific dates. Nutritional assessment completed by the dietitian on a specific date does not identify that resident #1 experienced swallowing problems during this time period.

During an interview with staff #107, he/she indicated that a resident who has difficulty chewing and/or swallowing should trigger a dietary referral.

During an interview with staff #107, when asked what direction is provided to the registered staff as to when to initiate a referral to the dietitian, he/she stated the registered staff would know when to send a referral and do so when they "see something different". There are no clear directions to the registered staff as to when to initiate a referral to the dietitian.

The licensee's policy "Referrals" taken from the nutrition services policy binder does not provide direction to registered staff as to when they should refer to the dietitian. [s. 6. (4) (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 there is a process in place to inform the registered staff as to when to refer to the registered dietitian, to be implemented voluntarily.

WN #2: 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 has failed to comply with O. Reg 79/10 26(3)14 in that resident #1's risk of hydration was not identified in his/her care plan.

Resident #1's plan of care indicates he/she had a diagnosis of dementia with delusions and agitation, received thickened fluids and required total assistance with all food and fluids.

During an interview with Staff #107, he/she indicated resident #1 would be at risk for dehydration due to his/her poor memory and requiring total assistance from staff to drink.

Nutrition assessments completed by the dietitian on specific dates indicate resident #1 was at high nutritional risk. Staff #100 stated resident #1 required total assistance with both eating and drinking and was difficult to feed as he/she required cueing to swallow.

On a specific date resident #1 returned from hospital with a respiratory infection. Resident #1's hospital discharge summary states "resident's po intake is quite poor so this will likely be an ongoing issue for him/her. We strongly encourage po fluids as he/she is unable to ask for them and can easily become dehydrated."

There are no progress notes or assessments completed to indicate resident #1's hydration status was assessed upon return from hospital. Resident #1's care plan printed May 14, 2013 does not identify any risks related to hydration.

Resident #1 passed away on June 8, 2013 with his/her immediate cause of death stated as dehydration. [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 residents who are at risk of dehydration have this risk identified in their plan of care, to be implemented voluntarily.

WN #3: 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 has failed to comply with O.Reg 79/10 s.8(1) in that they did not comply with the policies relating to nutrition care and dietary services and hydration as required under O.Reg 79/10 s. 68(2)(a).

A review of nutritional assessments completed on specific dates indicate resident #1 was at high nutritional risk due to low body weight and leaving 25% of food uneaten at most meals. Resident #1 is at risk for dehydration as indicated on his/her hospital discharge summary on a specific date.

The licensee's policy "Estimation of Food and Fluid Intake" taken from the nutritional services policies and procedures manual states that "utilizing the daily flow sheet and fluid intake sheets, the nutritional intakes for all residents shall be recorded after each meal and nourishment."

Upon reviewing the food and fluid flow sheets for resident #1, the 28 dates are either incomplete or had no information documented.

The food and fluid intake for resident #1 was not recorded as directed by policy "Estimation of Food and Fluid Intake".

The "Dyshpagia Managment" policy states "the RN/RPN will initiate a referral form to the Clinical Dietitian noting the areas of concern relating to signs and symptoms of dysphagia.

The food and fluid flow sheets have indicated resident #1 had a swallowing problem on eight specific dates.

Upon review of resident #1's health care record, there were no referrals to the dietitian

during a specific time period. Nutritional assessment completed by the dietitian on a specific date does not identify that resident #1 experienced swallowing problems during this time period. [s. 8. (1)]

2. The licensee's policy "Unplanned Weight Change" identifies an unplanned weight change as 7.5% or more over three months. The policy states any resident identified to have experienced unplanned weight change will be investigated by the Clinical Dietitian. The policy also states a written referral is to be made to the Clinical Dietitian using the Providence Manor Nutrition Services Memo form.

A review of resident #1's weight records indicate that during a specific two month period resident #1 had a significant weight loss of 3.4 kg (8.4%). Resident #1's health care record was reviewed and no referral was sent to the dietitian regarding this weight loss. A dietitian assessment completed during this time period does not acknowledge this significant weight loss.

There were no referrals sent to the dietitian to assess resident #1's weight loss. [s. 8. (1)]

WN #4: 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:

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; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(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 saillants :

1. The licensee failed to comply with O. Reg. s. 68(2)(d) in that there is not a system in place to accurately monitor the fluid intake of residents with identified risks related to nutrition and hydration.

The licensee's policy "Estimation of Food and Fluid Intake" taken from the nutritional services policies and procedures manual indicates that daily flow sheets and fluid intake sheets shall be used to record the nutritional intakes for all residents after each meal and nourishment.

Inspector observed three untouched glasses of fluid on a resident dining room table. Juice was in a 125 ml glass and water and milk 250 ml glasses.

During an interview with staff #102 he/she stated milk and water are in 250 ml glasses but juice is in 125 ml glasses. Staff #102 stated if a glass of juice and a glass of milk were taken at a meal "2" would be marked on the flow sheets to indicate 2 glasses were taken. Staff #102 acknowledged this system "does not makes sense" but stated this is what is to be done.

Staff #103 stated if a glass of milk and a glass of juice were consumed at a meal he/she would mark on the food and fluid intake sheets to indicate a resident had taken "2" glasses. Staff #103 was not aware of the quantity of fluids in the glasses and stated only the number of glasses of each fluid consumed is recorded on the sheet.

Staff #107 stated the food and fluid flow sheets are used to evaluate the resident's fluid intake. Staff #107 states every glass of fluid consumed is equivalent to 125 ml and this is the volume used to determine the resident's fluid intake.

There is not a system to accurately monitor and evaluate the fluid intake for resident #1 in that the system does not indicate the volume of fluid consumed therefore the fluid intake cannot be evaluated.

Resident #1 passed away on June 8, 2013 with dehydration noted as his/her immediate cause of death. [s. 68. (2) (d)]

Issued on this 7th day of January, 2014

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

Amber Moase, RD