Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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
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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
Oct 25, 30, 31, Nov 1, 9, 15, 16, 2012	2012_191107_0002	Follow up

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

BAYWOODS PLACE
330 MAIN STREET EAST, HAMILTON, ON, L8N-3T9

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 Follow up inspection.

During the course of the inspection, the inspector(s) spoke with Residents, front line nursing and dietary staff, Registered nursing staff, Food Services Supervisor, Registered Dietitian, Assistant Director of Care, and Administrator.

During the course of the inspection, the inspector(s) Reviewed the clinical health records of nine residents, observed meal service on two floors, and reviewed relevant policies and procedures related to follow up inspection H-002116-12.

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	Legendé
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 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. [O.Reg. 79/10, s. 69.1] Section 69 previously issued September 28, 2011 as CO#001.
The licensee did not ensure that resident #03 was assessed using an interdisciplinary approach, and that action was taken and outcomes were evaluated after a 16.3% significant weight loss over one month. Staff confirmed the significant weight loss was missed and also confirmed there was no referral to the registered dietitian for assessment of the weight loss. An assessment of the weight loss did not occur until almost two months later.
2. [O.Reg. 79/10, s. 69.1]
The licensee did not ensure that action was taken when resident #02 had a significant weight loss of 5% over one month. The registered dietitian reviewed the resident related to the significant weight loss and noted the resident had several meals less than 75% intake. Food and fluid intake records show the resident was consuming 79% of their meals at 1/2 or less over the month. The plan was to continue with the same interventions. No action was taken to address the noted poor intake. The resident was noted to have another significant weight loss the next month.
3. [O.Reg. 79/10, s. 69.1]
The licensee did not ensure that resident #05 was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated after a significant weight loss of 7.8% over one month. Documentation did not reflect that an interdisciplinary assessment, including an assessment of factors contributing to the significant weight loss, was completed by the interdisciplinary team. Staff interview confirmed that action was not taken by the home to address the weight loss. Staff confirmed that a multidisciplinary assessment of the weight loss had not occurred and that a dietary referral to the Registered Dietitian had not been initiated. The home's Weight Management policy and procedure (LTC-H-340) stated that the Food Services Manager/Registered Dietitian (FSM/RD) would be notified of significant weight change via the Nursing/Dietary Liaison Form completed by the Registered staff by the 15th of each month if the FSM or RD had not already addressed the weight change. The Nursing/Dietary Liaison Form had not been completed, despite the significant weight loss being identified on the weight exception form.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 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 saillants :

[O.Reg. 79/10, s. 26(4)(b)] Previously issued September 28, 2011 as CO #002
1. The registered dietitian did not assess resident #03's hydration status and risks related to hydration.
a) At the nutritional review in an identified month in 2012, there was no mention of the resident's hydration status. Food and fluid intake records for that month reflected the resident had not met their hydration requirement (minimum of 1500ml/day) on 31/31 days, with 24/31 days at less than 1000ml of fluid intake. According to the home's hydration policy, a referral to the registered dietitian was to occur for 3 consecutive days of fluid intake 1000ml or less, however, there were no referrals related to poor hydration noted in the resident's clinical record during that time. The dietitian reviewed the resident related to poor skin integrity at the end of the month, however, there was no mention of the poor hydration and interventions to address the poor hydration were not implemented. Prior to the nutritional review, the resident also had fecal impaction, ongoing diarrhea, open areas on the skin (stage 2-3), fever, significant hypotension, 58% of meals the first 2 weeks of the month taken at 50% or less, however, there was no assessment of the resident's hydration status in relation to any of the identified risk factors and in relation to fluid goals identified on the resident's plan of care.
b) The resident continued with poor hydration for the next three months (80% of the time not meeting hydration requirement, 79% the next month, and 93% the subsequent month), without a referral to the registered dietitian for the poor hydration and without an assessment by the registered dietitian of the ongoing poor hydration. In two of the three months the resident was also noted to have urinary tract infections requiring antibiotics.
c) At the Resident Assessment Protocol (RAP) for Nutritional Status, significant weight loss was noted, however, there was no mention of an assessment of the resident's hydration in relation to their identified fluid goal and of the poor hydration. Five out of seven days during the observation period the resident was not meeting their hydration requirement.
d) The resident was reviewed by the registered dietitian again related to a skin tear, however, there was no assessment of the ongoing poor hydration. The resident had not met their hydration requirement on 22/25 days prior to the dietitian review. Eleven of the 22 days had fluid intake less than 1000ml/day. No interventions were implemented to address the poor hydration.

2. The registered dietitian did not assess the nutritional and hydration status for resident #04 after a significant change in their food and fluid consumption.
a) The resident had a significant decrease in their food and fluid intake beginning three weeks prior to the quarterly review, however, this was not assessed by the Registered Dietitian in the Resident Assessment Protocol (RAP). The notes by the registered dietitian stated the resident had good intake at breakfast and 50-75% consumption at the lunch and supper meals. Food and fluid intake records reflected 89% of breakfasts were taken 1/2 or less (most were 1/4 or refused); 84% of the lunch meals and 70% of supper meals taken 1/4 or less over the three week time frame. The dietitian did not assess the significant decrease in food intake that occurred prior to the quarterly review and action was not taken to address the poor intake.
b) The resident also had a significant decrease in their fluid intake during the same time period. Prior to the decrease, the resident was consistently consuming more than 2000ml/day (goal for fluid intake was 1875ml/day), however, during the identified time frame the resident did not meet their hydration goal on any of the days monitored. The registered dietitian did not assess the resident's hydration status at the RAP; the RAP did not mention poor hydration and action was not taken to address the decreased fluid intake.

3. The registered dietitian did not assess resident #01's hydration status, and risks related to hydration at the dietary review related to newly diagnosed diabetes. The resident's blood glucose was significantly elevated (registering HI on the blood glucose meter), however, the review did not include an assessment of the resident's fluid intake or anything related to the hydration status of the resident. An assessment of the resident's hydration requirements was not included in the resident's clinical health record (computer or paper copy on the floor), preventing early identification of risks related to hydration. Hydration was not assessed/mentioned at subsequent nutritional reviews two and three months after the first review.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)] Previously issued January 28, 2011 as a VPC; February 28, 2011 as a VPC; and June 22, 2011 as a CO.
The licensee did not ensure that the care set out in the plan of care for the following residents was provided to the residents as specified in their plans:
a) The licensee did not ensure that the care set out in the plan of care for resident #09 was provided to the resident at the lunch meal October 25, 2012. The resident had a plan of care requiring thickened consistency fluids and they were at risk for aspiration pneumonia due to swallowing concerns. The resident was provided a consistency of fluids that was thinner than required and the resident was coughing significantly while consuming the fluids. Staff interview/record review confirmed that the resident required a thicker consistency of thickened fluids and staff confirmed that the fluids the resident was consuming were able to be poured from the glass (not thick enough), creating a risk for aspiration pneumonia.

b) Resident #08 had a plan of care requiring supervision and cueing at meals. The plan stated the resident would eat if sandwiches were placed in their hand. At the lunch meal October 31, 2012, the resident's sandwich was not placed in their hand until after they were sitting at the table not eating for more than 10 minutes. Only towards the end of the meal service did staff come and assist the resident with eating.

c) Resident #06:
i) The resident was not provided with the level of assistance required for eating as identified in their plan of care. The resident had a plan of care for constant supervision and encouragement with physical assistance if needed at all meals. The resident sat sleeping in-front of their meal for over 10 minutes with no assistance provided by staff. The resident's plate was removed without assistance being provided and the resident did not consume their meal.
ii) Resident #06 had a plan of care for the prevention of weight loss (resident was receiving nutritional supplementation several times daily and was several kilograms below their goal weight range), however, the resident was provided diet juice at the observed lunch meal October 30, 2012.

d) The licensee did not ensure that the care set out for resident #07 was provided to the resident as specified in their plan at the lunch meal October 30, 2012.
i) The resident had a plan of care that required double portions of meat at meals. At the observed lunch meal, the resident received a single portion of meat (sausage).
ii) The plan of care stated to cut the resident's food up into bite sized pieces, however, the resident received whole pancakes and sausage that was not cut up for the resident.
iii) The plan of care indicated the resident required encouragement at meals, however, the resident sat in-front of their hot meal for more than 15 minutes without encouragement or assistance by staff. The resident had their eyes closed at the table.

e) Resident #03:
i) The resident had a plan of care that required high protein milk, however, this was not provided to the resident at the lunch meal October 30, 2012. The diet list had not been updated to reflect the requirement for high protein milk. Staff serving the lunch meal were not aware that the resident requirement high protein milk at the meal.
ii) The resident had a plan of care that stated double portions of meat at meals, however, the resident was provided only a single portion of meal (sausage) at the observed lunch meal October 30, 2012. Staff interview confirmed the resident was not provided the double portion of meat by error.

2. [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 resident #03 so that their assessments were integrated, consistent with and complemented each other.
a) Progress notes completed by nursing staff on two specified days in one month, stated that resident #03 was drinking well. Food and fluid intake records, completed by the Personal Support Workers (PSW)s, indicated the resident was not drinking well (750ml, same as the day prior; 625ml and 750ml the day prior). The resident required a minimum of 1500ml as indicated on their plan of care. Information in the progress notes and on the food and fluid intake records was not consistent in the assessment of the resident's hydration status.
b) A progress note completed on a specified date the next month stated the resident was drinking well. Information completed by PSW staff indicated the resident was not drinking well (the resident had not met their hydration

requirement on the four days prior to the progress note. Information in the progress notes and in the food and fluid intake records was not consistent in the assessment of the resident's hydration status.

3. [LTCHA, 2007, S.O. 2007, c.8, s. 6(2)]
The plan of care for resident #05 was not based on an assessment of the resident's needs and preferences. The resident had a diagnosis of diabetes requiring medication and had a preference for skipping the breakfast meal. The resident's nutritional plan of care did not include this preference with strategies to ensure the resident's nutrition and hydration requirements were met with the skipped meal. Staff interview confirmed that staff were aware the resident did not attend the breakfast meal. The resident was not consistently meeting their hydration requirement for the past two months.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 LTCHA, 2007, S.O. 2007, c.8, s. 6 (4)(a), to be implemented voluntarily.

WN #4: 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 saillants :

1. [O.Reg. 79/10, s. 8(1)(b)] Previously issued June 22, 2011 as a WN, and September 28, 2011 as a VPC.

1. The licensee did not ensure that the home's hydration policy (LTC-H-130-ON) was complied with by staff in the care of residents #03 and #05. The policy stated that when a resident consumed less than 1000ml of fluid per day for three consecutive days, the Nurse/designate would notify the Physician/Nurse Practitioner and the Registered Dietitian/designate using the Nursing Dietary Liaison Tool.
a) Resident #05 had three consecutive days where their fluid intake was less than 1L (620ml, 870ml, 945ml), however, a Nursing Dietary Liaison Tool was not completed to notify the Dietitian of the poor hydration (as per direction in the policy). The resident had not met their hydration requirements on any day except two over a two month period. Staff interview confirmed a dietary referral was not completed.
b)Resident #03 consumed less than 1000ml of fluid per day on numerous consecutive days without referral to the Registered Dietitian as per the home's policy. The resident consumed less than 1000ml/day on 22 consecutive days in one month, and three consecutive days another month, without the completion of a Nursing Dietary Liaison Tool and referral to the registered dietitian for assessment.

2. The licensee did not ensure that the home's "Resident's Weight and Height" policy (LTC-H-340) was complied with by staff providing care to residents #05, #04, #03, and #02.
a) Resident #05 had a documented significant weight loss of 7.8% over one month, however, there was no re-weigh to verify the accuracy of the significant weight loss and no referral to the Dietitian using the Nursing/Dietary Liaison Tool. The policy stated that re-weighs would be completed immediately and the Nursing/Dietary Liaison Tool would be completed and sent to the Dietitian by the 15th of the month. A re-weigh was not completed until after the weight loss was identified by the inspector towards the end of the month.
b) The policy stated that the Food Service Manager (FSM) / Registered Deititian (RD) would be notified of significant weight changes via the Nursing/Dietary Liaison Form completed by Registered staff by the 15th of the month. A referral to the FSM/RD was not completed for a significant weight loss of 7.8% over one month for resident #04. Staff confirmed that a Nursing/Dietary Liaison Form had not been completed by October 15th for the weight loss, as per the home's policy.
c) The policy stated that if a resident's weight loss or gain was 2.0kg or greater from the preceding month, a re-weigh would be completed immediately and documented on the Monthly Blood Pressure and Weight Record. Staff confirmed that a re-weigh did not occur for resident #03 after a weight gain of 2.3kg noted over one month. A re-weigh did not occur until the 26th of the month.
d) The policy stated that the Food Services Manager (FSM)/Registered Dietitian (RD) would be notified of the weight change via the Nursing/Dietary Liaison Form completed by Registered staff by the 15th of the month if the FSM or RD had not already addressed the weight change. Resident #02 had a significant weight loss noted in the computer over one month. A referral to the Registered Dietitian, through the Nursing/Dietary Liaison Form, was not completed by Registered staff until the 23rd, resulting in a delay in follow up. The Registered Dietitian was unable to follow up until the next month.

3. The licensee did not ensure that the home's policy related to completion of documentation was complied with by staff providing care to resident #03.
a) The Administrator and Assistant Director of Care confirmed that home's policy for documentation of food and fluid intake was to complete the intake records as close as possible to the meal and snack service. It was identified that all breakfast and morning snack information should be in the food and fluid intake records by 0930 hours.
b) The food and fluid intake records for resident #03 were observed at 1130 hours on October 30, 2012 and did not contain any information related to the breakfast and morning snack pass (records were blank).
c) Staff interview confirmed the records were not completed as per direction from the home's Administrator.

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 system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #5: 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 saillants :

1. [O.Reg. 79/10, s. 68(2)(d)]
A system to monitor resident #05's food and fluid intake was in place, however, the system did not evaluate and identify risks related to nutrition and hydration.
a) Resident #05 had a plan of care requiring a fluid intake of 2150ml/day. The resident did not meet their hydration requirement on any day except two, over two months. An evaluation of the poor hydration did not occur, the risks related to the poor hydration were not identified, there was no referral to the Registered Dietitian for an assessment of the poor hydration, and interventions to correct the poor hydration were not implemented during the two month period. The resident was noted to have a urinary tract infection and high blood glucose due to a diagnosis of diabetes.
2. [O.Reg. 79/10, s. 68(2)(d)]
A system was in place to monitor the fluid intake of resident #04, however, a system that evaluated the resident's fluid intake and identified risks related to hydration, was not in place over a three week period. The food and fluid intake monitoring records showed the resident had a significant decrease in their hydration (almost 50% reduction) and they did not meet their hydration requirement (1875ml/day) on any day during this time frame. An interdisciplinary assessment of the poor hydration did not occur and interventions to address the poor hydration were not implemented.

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 the nutrition and hydration program includes 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.

Issued on this 19th day of November, 2012

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