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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 11, 2016	2016_205129_0003	000030-16/004153-16	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE BRAMPTON ON L6T 4B9

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

TALL PINES LONG TERM CARE CENTRE
1001 Peter Robertson Blvd. BRAMPTON ON L6R 2Y3

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

PHYLLIS HILTZ-BONTJE (129)

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 17, 18, 19 and 22, 2016

The following Log numbers were included in this inspection: #004153-16 related to continence care and # 000030-16 related to infection control,dining and snack service and nutritional care.

During the course of the inspection, the inspector(s) spoke with the resident's family members, the Administrator, the Acting Director of Care, the Supervisor of Care, Personal Support Workers, Registered Practical Nurses and Registered Nurses as well as dietary staff. During this inspection the resident was observed and care being provided to the resident was observed, clinical records were reviewed,records maintained by dietary staff were reviewed, investigative notes collected by the home were reviewed, e-mail correspondence was reviewed and the home's policies related to Continence Care and Bowel Management, Hydration Program and Weight Management were reviewed.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	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. (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. (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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident, [6(2)]
Resident #001's plan of care was not based on an assessment completed by the Speech Language Pathologist (SLP). On an identified date in 2015 the SLP assessed the resident and made specific recommendations for care related to feeding the resident, resident activity following meals, oral hygiene and monitoring the resident for specific signs of intolerance to the trial diet that had being ordered. Registered staff #005 confirmed that the document included in the resident's plan of care and used in the home to direct the specific care of residents was the care plan. A review of resident #001's plan of care, confirmed that the care plan did not include the specific recommendations for care made by the SLP.
-The care plan contained a care focus related to "eating", however interventions for care did not include the specific recommendations suggested by the SLP.
-The care plan contained a care focus related to "nutritional care" which identified the resident at high nutritional risk due in part to swallowing difficulties; other identified eating issues as well as an identified responsive behaviour during meal, but did not include the above noted feeding or monitoring interventions recommended by the SLP.
-The care plan contained a care focus related to "oral care". It was noted that interventions for oral care for resident #001 had not been altered since they were

implemented on an identified date in 2014 and this care focus did not contain the specific recommendation made by the SLP. [s. 6. (2)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed, in relation to the following: [6(10)(b)]
a) Resident #001 was not reassessed and the plan of care was not reviewed or revised when the resident's family identified a concern that the resident's fluid intake had decreased and the clinical record indicated that the resident had consumed significantly less fluid than was identified as being required in the resident's plan of care.

-The resident's plan of care identified a nutrition/hydration focus of care which included a goal that the resident "would meet estimated elevated nutrition/hydration needs". Interventions developed by the registered dietitian (RD) and in place at the time of this inspection, related to fluid consumption, included specific interventions. The fluid requirement identified by the registered dietitian in the plan of care represented a total of 3,000mls of fluid a day. Registered staff #003 confirmed that when personal support worker (PSW) staff documented the resident's fluid consumption in the computerized clinical record they documented the number of times the resident consumed a 125ml glass of fluid. The clinical records for January 2016 indicated the resident's daily fluid intake ranged from 1750ml to 625ml of fluid a day and on none of the 31 days had the resident consumed the identified fluid requirement. Clinical records for the first 21 days of February 2016 indicated the resident's daily fluid intake range had decreased to 1,000mls to 250mls of fluid a day and on none of the 21 days had the resident consumed the identified fluid requirement.
-Registered staff #003 confirmed that the system for monitoring records documented related to a resident's fluid consumption was through an automatic alert sent by the computerized documentation system to registered nursing staff when the resident had not consumed a specified amount of fluid over a three day period of time. Staff #003 also confirmed that it was the expectation that when registered staff received an automatic alert that action would be taken to assess the resident's decreased fluid consumption. A clinical alert report generated and printed by registered staff #003 confirmed that registered staff received multiple alerts which directed staff to document an assessment and necessary referrals, on January 9, 10, 11, 12,15, 20 and 21, as well as multiple alerts on February 12, 13, 21 and 22, 2016. Registered staff #003 and clinical

documentation confirmed that a dietary referral was not initiated by registered staff receiving the above noted decreased fluid intake alerts. A review of the progress note section of the computerized record confirmed that there were no notes written by registered staff to acknowledge the receipt of an alert related to decrease fluid consumption or to indicate that an assessment had been completed for resident #001.
-Registered staff and clinical documentation confirmed that staff did not take action to reassess resident #001 or review and revise the resident's plan of care when the resident's fluid intake volume deteriorated or when alerts were generated identifying that this resident had a decreased fluid intake.
b) Resident #001 was not reassessed and the plan of care was not reviewed or revised when the resident's ability to chew and swallow food deteriorated and documentation of the resident's food intake indicated food consumption had decreased.
-A review of the clinical records for the 43 meals documented over a 15 day period following the Speech Language Pathologist's (SLP) assessment of the resident indicated the resident was not eating well and had demonstrated several signs and symptoms of intolerance the SLP had alerted staff to observe for during several meals. Staff also documented through this period of time that the resident's family members had expressed concerned that the resident was not eating, consumed only fluids, and was coughing while eating.
-The SLP's documented assessment completed on an identified date in 2015 indicated a new diet was being ordered as a trial, directed that staff were to monitor for specifically identified signs and symptoms of intolerance and directed that if signs or symptoms of intolerance were presented the diet was to be downgraded and SLP was to be contacted.
-Clinical documentation of the amount of food consumed over the above noted 43 meals indicated that for 20 of those meals the resident consumed less than 50% of the food offered. A significant change was noted in the documentation of food consumed after the 20 meals noted above, when for 19 of the following meals staff documented the resident consumed 0 – 25% of food offered.
-Registered staff #003 provided a list of dietary referrals submitted during the above noted monitoring period. It was noted that two dietary referrals were submitted in December 2015, but neither of these referrals were to assess the resident's decrease in food or fluid consumption or observations staff had made related to the resident's poor tolerance of the ordered diet.
-Resident #001 was not reassessed and the plan of care was not reviewed or revised when the resident's ability to chew and swallow as well as documented food and fluid intake levels deteriorated.

c) Resident #001 was not reassessed and the plan of care was not reviewed or revised when the resident's bowel elimination patterns changed.
- Resident #001's physician had ordered one tablet of Senokot to be administered daily and also order the home's bowel protocol to be initiated for the resident under the circumstances identified in the protocol in order to manage bowel elimination.
- A review of clinical documents completed by personal support workers (PSW) for January 2016 indicated that the resident did not have a bowel movement on January 9, 10, 14, 15, 19 and 20, 2016. Clinical documentation indicated that during the month of January 2016 the resident continued to receive Senokot daily and that the bowel protocol was not initiated.
- A review of clinical documents completed by PSWs for the first 21days of February 2016 indicated the resident did not have a bowel movement on February 3, 4, 5, 6, 13, 14, 19, 20 and 22, 2015. Clinical documentation indicated that during the month of February 2016 the resident continued to receive Senokot daily and the bowel protocol was initiated on February 7, 15 and 22, 2016. This documentation confirmed that the resident's bowel elimination patterns changed during the first 21 days of February 2016, and resident demonstrated signs of constipation that required additional care interventions to be implemented.
- Documentation in the resident's clinical record indicated that a nutritional assessment was completed on February 19, 2016 that indicated the resident had demonstrated constipation over the last week and that no changes to the plan of care were made.
- Registered staff #007 confirmed that a reassessment of the change in the resident's bowel elimination pattern had not been completed and that the plan of care did not contain a care focus related to constipation [s. 6. (10) (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 and ensuring that the care set out in the plan of care is based on an assessment of the resident and that the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was assisted with getting dressed as required, and was dressed appropriately. [40]
Staff did not ensure that resident #001 was assisted in getting dressed and was dressed appropriately. Resident #001's substitute decision maker (SDM) visited the home at lunch time on an identified date to assist the resident with the noon meal and noted the resident was wearing the night clothes they were wearing on the previous evening. Resident #001's plan of care indicated that the resident required extensive assistance of two staff for dressing. When resident #001's SDM questioned staff about this staff responded by assisting the resident to dress in fresh clothing, the incident was reported to the Supervisor of Care and a Critical Incident Report was forwarded to the Ministry of Health and Long Term Care. Administrative staff immediately initiated an investigation where it was confirmed that the staff person who had been assigned to provide care to the resident on the day shift of the identified date intended to return to assist the resident to change their clothing following morning care, but did not. The investigation confirmed that following the provision of personal care staff assisted the resident from the bed into a wheelchair and then prior to lunch assisted the resident to the dining without having ensured that the resident had been assisted to dress in clean clothing. [s. 40.]

Issued on this 27th day of April, 2016

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

Original report signed by the inspector.