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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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 14, 2014	2013_238501_0003	T-1-13C	Complaint

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

CUMMER LODGE
205 CUMMER AVENUE, NORTH YORK, ON, M2M-2E8

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

SUSAN SEMEREDY (501)

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): December 18, 20, 30, 2013.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Assistant Administrator, Nutrition Manager, Registered Dietitian (RD), Spiritual/Religious Care Co-ordinator, family member and residents.

During the course of the inspection, the inspector(s) observed one meal service, reviewed health records for identified residents and reviewed policies and menus.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the residents' right to be properly fed and cared

for in a manner consistent with his or her needs was fully respected and promoted for Resident #1 and Resident #3.

Cummer Lodge, the home of Residents #1 and #3, failed to operate as a place where Residents #1 and #3 have their spiritual and cultural needs adequately met.

Resident #3 was admitted to Cummer Lodge and was identified as a particular faith. The observance of his/her religion required specialized food. Upon admission it was identified that Resident #3 requested this specialized food. Record review and resident interview confirmed that Resident #3's choice would be to have this particular specialized food. Record review revealed that during admission Resident #3 was told that Cummer Lodge was unable to supply these specialized meals in-house. Record review and staff interviews confirmed that Resident #3 was provided specialized meals approximately six times per week. Staff interviews confirmed these meals have been paid for through a government support program. Resident interview revealed that he/she wishes to have specialized meals and would like to have these meals on a more regular basis but that no one has asked or given him/her this option.[s. 3. (1) 4.]

2. Resident #1 was admitted to Cummer Lodge and was identified as being of a particular faith. Record review and family interview revealed that Resident #1 is of a particular creed requiring him/her to have specialized foods as part of his/her religious observance. Record review and family interview revealed that Resident #1 has had specialized food all his/her life. Family confirmed that Resident #1 is very religious, always has been and chooses to have specialized food. According to the family, prior to being admitted to Cummer Lodge, resident was at a retirement residence where he/she received specialized meals as part of the accommodation. Record review revealed and staff and family interviews confirmed that prior to admission, his/her family members were under the impression that the home provided this specialized food but were told it would be the family's responsibility to order, arrange delivery and pay for this food. Record review and staff and family interview confirmed that the family of Resident #1 arrange and pay for specialized lunch and dinner meals daily; the home provides prepackaged cereal and pudding for breakfast as well as beverages and snacks. The family arranges for the delivery and payment of these specialized meals and Cummer Lodge stores, reheats and serves them. Cummer Lodge also provides disposable cutlery and Styrofoam cups in keeping with this special dietary law.
Interview with the licensee revealed that Cummer Lodge does not provide particular specialized meals for residents because they do not have a separate special kitchen.

According to the licensee their role is to ensure that the residents' families know where to purchase these specialized meals. The licensee does offer an adjustment to the home's menu known as a particular style of menu which excludes certain menu items. The licensee stated that they are aware that the family of Resident #1 was not interested in this particular style menu and that the family has been paying for specialized meals to be brought in twice a day since admission. [s. 3. (1) 4.]

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 the residents' right to be properly fed and cared for in a manner consistent with his or her needs is fully respected and promoted, to be implemented voluntarily.

WN #2: 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. (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. (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).

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. Clear direction was not provided to staff in reference to Resident #3's religious dietary practice of avoiding consumption of certain products. The diet list available to staff serving stated "do not serve a particular food item". The modified menu for Resident #3 offered this item at breakfast and lunch. An interview with the RD confirmed that the resident was not to receive this food item and these items on the menu were oversights and should be removed.
Clear direction was not provided in reference to the administration of an intervention for constipation for Resident #3. The physician's order and physician medication review had conflicting statements with no directions on how it should be provided. The care plan in one section gave one direction however in another section of the care plan another direction was documented. An interview with the RD identified that the resident originally received a certain amount of the intervention but then the resident requested more. The RD could not confirm how the intervention was being

administered and needed to interview the resident to confirm.
The RD confirmed that there are parts within Resident #3's plan of care that are inconsistent and there is a lack of clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the assessments and plan of care are integrated and are consistent with and complement each other related to food allergies and resident's need for special foods related to his/her spiritual needs. Resident #3 is of a particular faith, prefers special meals as part of his/her religious observance and has confirmed multiple food allergies.
A record review of the master profile in Resident #3's plan of care identified resident has multiple food allergies. The physician medication review identified Resident #3's allergies as different than those in the master profile. The written care plan for Resident #3 refers to only 2 allergies. The diet list available to meal service staff did not have any reference to food allergies and only stated to "do not serve a particular food item" without any identification of planned meals with specialized food. The resident's individualized menu included foods identified as allergies according to other components of the plan of care.
An interview with the RD revealed that Resident #3's planned menu is not based on all of the resident's confirmed allergies and need for specialized food as part of his/her religious observance. [s. 6. (4) (a)]

3. The licensee failed to ensure that Resident #3 is reassessed and plan of care reviewed and revised at least every six months and at any other time when care needs change or the care set out in the plan has not been effective.
Record review revealed that Resident #3 receives specialized meals approximately six times per week from an outside agency. Resident interview revealed that he/she would prefer to have specialized meals for all lunches and dinners. Record review and staff interviews revealed that the resident's religious needs have not been re-assessed and the preference to have more specialized meals has not been addressed. [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 to ensure that there is a written plan of care for Resident #3 that sets out clear direction to staff and others who provide direct care to the resident, 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. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. Resident #1's spiritual need for particular foods was not met through the home's menu cycle. Resident #1 was admitted to Cummer Lodge and is of a particular creed, had specialized food all his/her life and requires specialized food as part of his/her religious observance. Resident #1's plan of care was developed by the RD and did not include an individualized menu. The resident's dietary plan of care and menu was incomplete as the provision of lunch and dinner meals has been left to the family. Observation and interviews confirmed Resident #1 received and consumed a specialized meal purchased by family at lunch on Monday, December 30, 2013. [s. 71. (5)]

2. Resident #3's spiritual need for specialized foods and his/her need for avoiding allergens was not met through the home's menu cycle.
Resident #3 was admitted to the home, is of a particular creed and requires specialized foods as part of his/her religious observance. Record review and interviews revealed that Resident #3 receives specialized meals approximately six times per week. Resident #3 stated he/she would like to have specialized food for all meals; not just a few meals a week.
A record review and staff interview confirmed that Resident #3's modified menu was developed by the RD and was based on a certain menu type due to a possible allergy. Record reviews identified several other food allergies. Interview with the RD confirmed that specialized meals included on the menu may not be allergy free and was unable to confirm this during the inspection. Review of the menu revealed the inclusion of foods which the resident is documented as being allergic to.
Resident #3's menu was incomplete as it did not meet his/her spiritual needs on a regular basis and did not meet her need to avoid foods that are documented as allergens. [s. 71. (5)]

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 an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that it shall not cause or permit anyone to make a charge or accept a payment on the licensee's behalf that the licensee is prohibited from charging for under the legislation.

Resident #1 is currently living in Cummer Lodge and is of a particular creed and requires specialized foods as part of his/her religious observance. Cummer Lodge does not have a special kitchen and record review as well as family and staff interviews revealed that the licensee will not order or pay for specialized food to be brought in to the home. Family interview confirmed that they have been arranging and paying for specialized lunch and dinner meals to be brought to the home at a cost of $6.95 per meal since Resident #1 was admitted. Staff interviews revealed they are aware Resident #1's family is paying for these meals and the licensee confirmed that they have not offered or at any time given compensation or subsidization to the resident or family for these meals. [s. 91. (4)]

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 the licensee shall not accept payment form or on behalf of a resident for anything that the licensee is prohibited from charging for under the legislation and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf, to be implemented voluntarily.

WN #5: 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. (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 O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The RD failed to assess the risks of multiple food allergies relating to nutrition care.

A record review identified that Resident #3 was admitted with multiple food allergies and these allergies were identified in the master profile in resident's current plan of care. Record review identified allergy testing had been completed by a physician which identified a list of foods to be avoided. Associated with these allergies, are 14 foods commonly found on long term care menus. Record review revealed that the RD failed to assess the risks relating to the consumption of these foods and the potential nutritional impact of avoiding multiple foods. Food allergens which Resident #3 was noted to be allergic to were identified on resident's menu. The RD was unable to confirm if a nutritional assessment related to resident's multiple food allergies was completed. [s. 26. (4)]

Issued on this 14th day of January, 2014

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

S. Kennedy