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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimile: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
August 30, 31, September 1, 2010	2010_159_1078_27Aug145800	Dietary Follow-Up H-01543

Licensee/Titulaire

Mississauga Long term Care facility Inc.
26 Peter Street North
Mississauga ON
L5H 2G7

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

Mississauga Long Term Care Facility
26 Peter Street North
Mississauga ON
L5H 2G7

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

Asha Sehgal #159

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow up inspection in respect of the following previously identified non-compliance:

March 13, 2009 -B1.2	LTCHA 2007, c. 8, s. 6(5)	
March 13, 2009- B1.6	LTCHA 2007, c. 8, s 6(10) (b)	O.Reg. 79/10, s. 69 (1) (2) (3)
March 13, 2009- B2.4	LTCHA 2007, c. 8, s 6(1) (a) (b) (c)	O.Reg. 79/10, s 26 (1) (3)
March 13, 2009- B3.23	LTCHA 2007, c. 8, s 6 (7)	O.Reg. 79/10, s 24 (6) 71 (5)
March 13, 2009- P1.4	O.Reg. 79/10, s 71 (2)	
March 13, 2009- P1.14	O.Reg. 79/10, s 72 (1) (2) (3)	

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, RAI Coordinator, Food Service Manager, Dietary Aides, Cook, Nursing Staff (RPN, RN, PSW), and Residents.

During the course of the inspection, the inspector:
Toured the home, Reviewed health care records, observed meal service (Breakfast and lunch meals afternoon nourishment pass),observed Part of the noon meal food preparation, observed care, observed staff in routine duties.

The following Inspection Protocols were used:
Nutrition and Hydration
Dining Observation
Food Quality

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

[8] WN
[8] VPC

Corrected Non-Compliance is listed in the section titled Corrected Non-Compliance.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, c. 8, 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, (c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. The plan of care of an identified resident did not provide clear directions related to resident's weight gain, inadequate fluid consumption and constipation. The plan of care did not include clear objectives, goals and needs specific to the resident. The plan of care did not address nutrition interventions for inadequate fluid consumption, medical diagnosis and constipation.

Inspector ID #:	159

Additional Required Action:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S. O. 2007, c. 8, 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, (b) the resident's care needs change or care set out in the plan is no longer necessary.

Findings:

The plan of care of resident was not reviewed and revised upon returning from hospital. The resident had returned from the hospital with significant changes. The hospital record stated diagnosis UTI, monitor out put, diet modified pureed texture, thickened fluids and abnormal lab results The plan of care of the resident was not reflective of the change in health status documented in the health record.

Inspector ID #:	159

Additional Required Action:

VPC - pursuant to the *Long-Term Care Homes Act, 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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change to be implemented voluntarily.

WN #3: The Licensee has failed to comply with: : LTCHA, 2007, c. 8, s. 6 (11) (b)

When a resident is reassessed and the plan of care reviewed and revised, 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.

Findings:
The plan of care of an identified was not revised based on the resident's needs. Interventions set out in the plan of care have not been effective for weight maintenance and chronic constipation. Resident's fluid intake record for August 13, 2010 to August 28, 2010, indicated decreased fluid consumption, August 13, 2010 - 750 ml. August 14, 2010- 765 ml. and August 16, 2010, 575 ml./day. There was not evidence to support that resident's nutritional care needs (i.e. chronic constipation, hydration and weight maintenance) were reassessed and interventions evaluated.

Inspector ID #:	159

Additional Required Action:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, c.8, s.152 (2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that When a resident is reassessed and the plan of care reviewed and revised, 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 to be implemented voluntarily.

WN #4: The Licensee has failed to comply with : LTCHA, 2007, c. 8, 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.

Findings:
An identified resident was known to be diagnosed with dehydration and urinary tract infection as per hospital record. Resident also had experienced weight loss. The changes in resident's health status were not communicated to all staff involved in the different aspects of care. There was no supportive documentation that the nutrition assessment was completed by Registered Dietitian used an interdisciplinary approach. The plan of care of the resident did not identify nutrition risk related to dehydration, urinary tract infection, and weight loss.

Inspector ID #:	159

Additional Required Action:

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 staff and others involved in the different aspects of care of the resident collaborate with each other to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, c. 8, 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.

Findings:
1. At the breakfast meal on the 1st floor on August 30, 2010, an identified resident was served a meal tray in room. The breakfast meal served consisted of 125 ml glass of milk and apple juice 125 ml, tea/coffee was not offered to the resident. The resident received only 2 beverages, 250 ml fluid.

Resident's plan of care stated encourage resident to increase fluid intake. The resident did not receive adequate fluids or encouragement to consume additional fluids.

2. At the breakfast meal August 30, 2010, an identified resident on a renal diet received 125 ml milk, 125 ml apple juice, ½ bowl hot cereal, 1/2 blue berry muffin The renal diabetic menu called for 125 ml. apple juice or prune juice, hot oatmeal, fruit yogurt or peanut butter, blue berry muffin or white toast. The planned renal diabetic menu posted was not followed by the dietary staff serving food, resulting resident not receiving full breakfast and correct diet.

Inspector ID #:	159

Additional Required Action: [

VPC - pursuant to the *Long-Term Care Homes Act, 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 care set out in the plan of care is provided to the resident as specified in the plan to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg. 79/10, s. 26 (3)
A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
13. Nutritional status, including height, weight and any risks relating to nutrition care
14. Hydration status and any risk relating to hydration.

Findings:

1. The plan of care of an identified resident was not based on a full nutrition assessment. The triggered Resident Assessment Protocol (RAP) for dehydration was not care planned with goals minimizing and avoiding complication associated with dehydration. The plan of care did not include care planning for medical diagnosis and fluctuating blood sugars and risks related to nutrition care i.e. dehydration.

2. The nutrition assessment and the plan of care of an identified resident were not consistent with each other. The plan of care did not include risks related to medical diagnosis, decreased fluid intake and constipation. The resident did not have a comprehensive nutrition assessment in relation to chronic constipation, medical diagnosis and hydration.

3. An identified resident's plan of care was not based on an interdisciplinary assessment for hydration. The plan of care of the resident did not reflect current resident's hydration status and risk related to hydration. The resident's plan of care did not include diagnosis of urinary tract infection and poor fluid consumption as evidenced in the progress notes.

Inspector ID #:	159

Additional Required Action:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, c.8, s.152 (2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Nutritional status, including height, weight and any risks relating to nutrition care to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg. 79/10, 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 paragraph 13 and 14 of sub sec (3)

Findings:

1. The Registered Dietitian did not complete nutritional assessment for an identified resident upon readmission of the resident returning from the hospital. Review of Hospital transfer record indicates that the resident had a significant change in the health condition including diet change. There was no supportive documentation that the Registered Dietitian completed nutritional assessment for the resident related to change in health condition i.e. weight loss, dehydration, UTI, abnormal lab values, and diet change.

2. An identified resident did not have a nutritional assessment that include evaluation and care planning of diagnosed syndrome. The resident did not receive a complete nutrition assessment by the Registered Dietitian in relation to chewing and swallowing ability, medical diagnosis, hydration and fluctuating blood sugar. A review of resident's food and fluid intake record August 13, 2010 to August 28, 2010 indicated fluid consumption less than 1500 ml a day. Resident's assessed hydration needs 2300 ml/day, noted documented by the Registered Dietitian in quarterly assessment summary August 1, 2010. The registered dietitian did not reassessed resident for poor fluid intake.

3. An identified resident did not have a nutritional assessment in relation to weight gain, and risks related to medical diagnosis, hydration, and chronic constipation. The nutrition assessment completed July 31, 2010, by Registered Dietitian did not include estimation of nutritional requirement (kcalories, protein, fluid and micronutrient) needs.

Inspector ID #:	159

Additional Required Action:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, c.8, s.152 (2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that a registered dietitian who is a member of the staff of the home, completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O. Reg, 79/10, s. 69. 1 and 2
Every licensee of a long term care home shall ensure that residents with the following 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.

Findings:

1. An identified resident was not assessed by the registered dietitian after a 7. 69 % (5 kg) weight loss over one month in August, 2010 and care planning interventions have not been revised or implemented to address the weight loss.

2. An Identified resident had a documented unplanned weight gain of 10% over 3 months (June 2010 - August 2010) The progress notes indicate that a referral to the dietitian was initiated June 18, 2010,

however, it has not been completed to date.(August 31, 2010). The resident had not been assessed and measures not taken to address the problem.

Inspector ID #:	159

Additional Required Actions: [
VPC - pursuant to the *Long-Term Care Homes Act, 2007*, c.8, s.152 (2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that residents with the following 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 to be implemented voluntarily.

CORRECTED NON-COMPLIANCE
Non-respects à Corrigé

REQUIREMENT EXIGENCE	TYPE OF ACTION/ORDER	ACTION/ ORDER #	INSPECTION REPORT #	INSPECTOR ID #
LTCHA, 2007, S.O. 2007 c. 8, s.6(5) previously issued B1.2			March 13, 2009	
O. Reg. 79/10, s. 71 (2) Previously issued P1.4			March 13, 2009	
O. Reg. 79/10, s.72 (1) (2) (3) Previously issued P1.14			March 13, 2009	

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Revised for the purpose of publication. [signature] reassigned Aug 5/11
Title: Date:	Date of Report: (if different from date(s) of inspection).