Ontario

# 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
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| Date(s) of inspection/Date de l'inspection | Inspection No/ d'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| September 15, 16, 2010 | 2010_110_2835_15Sep093447 | Follow-up |

**Licensee/Titulaire**
Orillia Long Term Care Centre Inc.
689 Yonge Street, Midland, ON
L4R2E1

**Long-Term Care Home/Foyer de soins de longue durée**
Leacock Care Centre
25 Museum Drive,
Orillia, ON
L3V7T9

**Name of Inspector(s)/Nom de l'inspecteur(s)**
Diane Brown (110) and Catherine Palmer (152)

## Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow up dietary inspection related to nutritional care.

During the course of the inspection, the inspector(s) spoke with: Administrator, Registered Dietitian, Director of Care, Registered Nurses, Registered Practical Nurses, Food Service Supervisor, Personal Support Workers, Dietary Aides, Corporate Dietary Consultant,

During the course of the inspection, the inspector(s): meal and nourishment observation, record reviews, policy review,

The following Inspection Protocols were used in part or in whole during this inspection:
Nutrition and Hydration Inspection Protocol

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

[12] WN

## 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

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| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.<br><br>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.<br><br>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 S.O. 2007 c. 8 s. 11 (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11 (2).

**Findings:**

1. The licensee failed to ensure that a plan of care is in place that addresses measures to prevent choking for an identified resident. Progress notes for the resident dated May 21, 2010, June 7, 29, 2010, July 19, 2010, August 23, 2010, September 7 and 8, 2010 note family member feeding resident foods not suitable to diet texture order. Speech language pathologist progress note of August 6th, 2010 notes resident is

high aspiration risk related to consumption of foods provided by family.
2. Plan of care for identified resident specifies to provide specialized diet related to high risk for aspiration. At lunch on September 15, 2010 identified resident was provided incorrect diet texture.
3. Identified resident's one day meal pattern developed for a specialized diet does not provide for a variety of tastes and food/fluids. Resident receives the same breakfast, lunch and dinner each day with only a day to day variation with soup.

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**WN #2:** The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 c. 8 s. 6. (1) (c). 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. 2007, c. 8, s. 6 (1).

**Findings:**
1. Identified resident's plan of care includes contradictory goals for fluid needs. This resident's fluid goals have been stated as both 1300mls and 1470mls throughout the plan of care.
2. Plan of care direction to provide high potassium foods at snacks for identified resident is not clear to staff providing care. Resident did not receive a high potassium snack at observed afternoon nourishment pass September 15, 2010.

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**WN #3:** The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 c 8 s. 6. (10) (b). 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:**
1. There is no evaluation of identified resident's current plan of care for modified fluids. There is no documentation in the plan of care, including speech language pathologist's note of August 6th, 2010 that indicates modified fluids are a safe alternative for resident.
2. Dietitian assessment of July 16, 2010 indicates plan to convert some of resident's modified fluids to alternate consistency. The registered dietitian failed to follow through on the plan.
3. Identified resident at high nutritional risk related to difficulty swallowing, significant and ongoing weight loss, and poor nutritional intake did not have plan of care evaluated in response to weight loss and poor nutritional intake by the homes registered dietitian since May 17, 2010. There is no documented assessment(s) to determine if the planned meal pattern is meeting resident's nutrition and hydration needs and food/fluid preferences since May 17, 2010.

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**WN #4:** The Licensee has failed to comply with LTCHA, 2007 S.O. 2007 c. 8 s.6. (10) (c). 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, (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

**Findings:**
1. Interventions for identified resident, related to weight loss and poor food/fluid intake, were not reassessed in response to progress notes between August 25, 2010- September 1, 2010 indicating periods of

resident's poor food/fluid intake(less than 50% meals for the last three days).

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

**Findings:**

1. On July 16th, 2010, the home's registered dietitian trialed and recommended a specific flavored menu item as part of identified residents specialized diet as the resident enjoyed the taste. The resident's plan of care was modified July 18th, 2010 by the food service supervisor to an alternative flavored menu item without an assessment of resident preferences.
2. Identified resident's plan of care is not based on an assessment of food preferences. Resident did not achieve plan of care goal "to eat 75% -100% of each meal" for 92% of meals provided in July; 65% of meals provided in August, and 67% of meal provided in September (up until September 15th, 2010).
3. There is no assessment of identified resident's plan of care for provision of modified fluids. The speech language pathologist's most recent swallowing recommendations of August 6, 2010 are not consistent with the plan of care. There is no documentation in the plan of care, including speech language pathologist's note of August 6th, 2010, that modified menu items are a safe alternative for resident.

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**WN #6:** The Licensee has failed to comply with LTCHA, 2007 S.O. 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. 2007, c. 8, s. 6 (7).

**Findings:**

1. Staff failed to provide identified resident with the nutritional care, set out in the plan of care at lunch September 15th, 2010.
2. Staff failed to provide identified resident with the nutritional care, set out in her plan of care, at afternoon nourishment September 15th, 2010.
3. At lunch September 15, 2010 staff failed to provide identified resident complete support for eating and drinking to meet nutritional needs according to plan of care. Resident was not assisted with 50% of the meal.
4. Staff failed to provide identified resident with prescribed consistency of fluids for safe swallowing at observed lunch meal September 15, 2010.
5. Staff failed to provide identified resident dessert as per plan of care at lunch meal September 15, 2010.

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**WN #7:** The Licensee has failed to comply with O. Reg. 79/10 s. 26(3)13., 26(3)14., 26 (4) (b).

26(3)13. 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. 26(3)14. 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. 26(4)(b). 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:**

1. Identified resident's progress note documentation August 14th, 29th and 30th states resident's meal intake was "less than 50% for last three days". Registered staff failed to take action.
2. The home's registered dietitian failed to assess all risks related to nutrition for an identified resident. Registered dietitian documentation of July 15, 2010, July 16, 2010, August 8, 2010 did not include an evaluation of poor food and fluid intake despite nursing documentation on May 28, 2010, June 4, 2010, June 24, 2010, July 22, 2010, July 30, 2010, August 11, 2010, August 15, 2010, August 16, 2010 of resident's poor three day food/fluid intake. There was no assessment of the risk of poor food and fluid intake by other members of the interdisciplinary team.
3. The home's registered dietitian failed to assess all risks related to hydration for identified resident. Registered dietitian documentation of July 15, 2010, July 16, 2010, August 8, 2010 did not include an evaluation of poor food and fluid intake despite nursing documentation May 28, 2010, June 24, 2010, August 11, 2010, August 15, 2010, August 16, 2010 of resident's poor three day fluid intake. There was no assessment of the risk of poor fluid intake by other members of the interdisciplinary team.
4. Registered staff failed to take action in response to identified resident's poor fluid intake (less than 50% for last three days) documented August 25, 2010 in the progress notes. There was no assessment of the risk of poor fluid intake by other members of the interdisciplinary team.
5. Identified resident had a 5% weight loss from August 20-27 2010. The registered dietitian's September 1, 2010 weight warning dietary progress note failed to assess the impact of resident's documented poor food and fluid intake as a risk related to nutrition and hydration status.
6. Dietitian assessment of July 16, 2010 indicates plan to convert some of identified resident's modified fluids to an alternate consistency. There has been no follow up action with this plan.
7. Identified resident, at high nutritional risk, related to poor intake, ongoing weight loss, and difficulty swallowing did not have plan of care assessed by the homes registered dietitian to determine if the planned interventions meet nutrition and hydration needs since May 28, 2010.

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**WN # 8:** The Licensee has failed to comply with O. Reg. 79/10 s. 68(2) (d)
Every licensee of a long-term care home shall ensure that the programs include, (d)a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

**Findings:**

1. The home's registered nursing staff failed to evaluate identified resident's poor food/fluid intake as documented in progress notes dated August 14, 2010, August 25, 2010, August 29, 2010, August 30, 2010 in accordance with the home's Hydration-Referral policy dated August 2009.
2. The home's registered nursing staff failed to evaluate identified resident's poor food/fluid intake as documented in progress notes dated May 28, 2010, June 4, 2010, June 24, 2010, July 22, 2010, August 11, 2010, August 15, 2010, August 16, 2010 in accordance with the home's Hydration-Referral policy August dated 2009.

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**WN #9:** The Licensee has failed to comply with O. Reg. 79/10 s.69. 2. 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: 2. A change of 7.5 per cent of body weight, or more, over three months.

**Findings:**

1. Identified resident's nutrition and hydration plan of care outcomes were not evaluated in response to weight loss of 7.5% body weight July, 14, 21, August 4 and 18 , 2010

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**WN #10:** The Licensee has failed to comply with O. Reg. 79/10 s.69. 3. 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: 3. A change of 10 per cent of body weight, or more, over 6 months.

**Findings:**

1. Identified resident's nutrition and hydration plan of care outcomes were not evaluated in response to weight loss of 10% body weight July, 7th, August 12th and September 8th 2010.

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**WN #11:** The Licensee has failed to comply with O. Reg. 79/10 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:**

1. There is no individualized menu plan for identified resident whose needs cannot be met through the home's menu cycle.

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**WN #12:** The Licensee has failed to comply with O. Reg. 79/10 s. 73(2)(b). The licensee shall ensure that, (b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

**Findings:**

1. Staff failed to assist identified resident with lunch meal September 15, 2010 according to the plan of care that indicates the need for total support for eating and drinking. Resident was not assisted with the meal for at least 35 minutes after menu items were served. Resident's intake was poor at this observed meal.

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| Signature of Licensee or Representative of Licensee<br>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. |
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| | D Brown & Cathy Palmer |

| Title: | Date: | Date of Report: (if different from date(s) of inspection). |
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| Administrator | Oct 14/10. | Oct 14, 2010 |