Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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
May 24, 27, 30, 2011	2011_027192_0020	Complaint

Licensee/Titulaire de permis

CITY OF HAMILTON
77 James Street North, Suite 400, HAMILTON, ON, L8R-2K3

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

MACASSA LODGE
701 UPPER SHERMAN AVENUE, HAMILTON, ON, L8V-3M7

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'Inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Registered Nurse, Registered Practical Nurse, Personal Support Workers, Recreationist, and Food Services Supervisor.

During the course of the inspection, the inspector(s) reviewed medical records, incident reports, and policy and procedure. Spoke with resident and family members and observed a medication pass.

The following Inspection Protocols were used in part or in whole during this inspection:

Continence Care and Bowel Management

Falls Prevention

Medication

Nutrition and Hydration

Pain

Personal Support Services

Recreation and Social Activities

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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).

Findings/Faits sayants :

1. The licensee did not ensure that staff and others involved in the different aspects of care for a specified resident collaborated with each other in the assessment of the resident so that their assessments are integrated and are consistent with each other.

On a specified date, a specified resident sustained a fall with injury. The medical record for the resident does not indicate that an interdisciplinary assessment was completed related to safe lifts and transfers and based on abilities at different times of the day. It was determined during interview that different shifts utilize different lift/transfer techniques. The plan of care indicated under transferring that the resident required the Maxi Lift for transfers and under toileting that the Sara Lift (sit to stand) was to be used. A family member had been informed that a specific type of transfer was unsafe for the resident.
The resident's condition had changed. No interdisciplinary assessment, was completed related to these changes in condition.
2. A specified resident was participating in approximately two programs each week through October of 2010, with the nature of the programs being varied and including activity on the home area, and large group activity. There has been a significant decline in the level of participation for this resident with the resident only attending recreational activities occasionally through a specified period of time.
There has been no assessment by the home related to these changes and the resident's participation in recreation activities.
There has been no interdisciplinary conference to attempt to address the scheduling challenges that are preventing the resident from attending recreational activities that there had been an expressed interest in attending previously.
3. A specified resident experienced a change in condition. Investigation was initiated, concern expressed by family members was not addressed on two occasions. A review of the Daily Intake Flow Sheet indicates that there was a decline in the residents intake of food and fluid. No dietary referral was made with this change in condition.
During interview with the RN it was identified that it was believed this change in condition was related to an alternative cause.
There is no evidence in the medical record of an assessment of residents change in condition.

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 ensuring that staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other., to be implemented voluntarily.

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 sayants :

1. A specified resident experienced changes in condition related to nutritional status. The resident then sustained a fall with injury. No dietary referral was completed and the resident was not seen by the dietitian in spite of changes in condition and appetite.

Issued on this 6th day of July, 2011

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