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 22, 23, 2010	2010-165-9552-20Sep160619	Follow up H-02191

Licensee/Titulaire
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(s)

Tammy Szymanowski , LTC Home Inspector-Dietary - #165; Michelle Warrener, LTC Home Inspector-Dietary - #107

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow up inspection.

During the course of the inspection, the inspectors spoke with: the Administrator, Director of Food Services, Food Service Supervisor, residents, resident family members, dietary staff and nursing staff.

During the course of the inspection, the inspectors: observed production and reviewed production system including standardized recipes, observed meal service in C2E wing, C3E wing, D wing and A3 wing, observed PM nourishment cart, reviewed current menu cycle, reviewed resident council minutes, reviewed nutritional policies FS-09-01-02 and FS-09-01-08, reviewed quality management program, and reviewed resident plans of care.

The following Inspection Protocols were used during this inspection: Food quality inspection protocol, dining observation inspection protocol, and quality improvement inspection protocol.

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

[7] WN
[5] 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 the *LTC Homes Act, 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, clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1)(c).

Findings:

1. The plan of care for an identified resident did not provide clear direction for staff related to the level of assistance at meal times.
2. An identified resident has a Physicians' order for a specialized diet and texture however, the current diet list does not indicate the diet as ordered by the Physician.
3. An identified resident's plan of care indicates specialized interventions for meal replacements however, the interventions are not consistent with guidelines for the specialized menu choices.
4. The written plan of care for an identified resident does not provide clear direction in relation to the diet texture to provide to the resident. The kardex plan indicates that assistive devices are required, however does not indicate which devices are required.
5. The written plan of care for an identified resident does not provide clear direction to staff in relation to the level of assistance required with eating. The plan in the kardex (available for staff) stated limited assistance required, however, the computerized version indicates total assistance with one person physical assist. Interventions previously identified related to Palliative care are not appropriate for the current status of the resident.
6. The plan of care for an identified resident on a specialized diet does not provide clear direction to staff.
7. The written plan of care for an identified resident does not provide clear direction to staff in relation to the resident's diet order.

Inspector ID #:	#165 and #107

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 with providing 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 the *LTC Homes Act, 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. Plan of care for an identified resident indicates interventions including: assistance, seating for meal times and communication with family when resident refuses the diet texture as ordered however, the interventions have not been followed and re-evaluated.

2. The plan of care for an identified resident indicates that one staff is to provide total feeding during meals however, the resident did not receive the level of assistance with eating until thirty five minutes into the lunch meal September 23, 2010 when the RPN was finished passing medications.

3. An identified resident's plan of care indicates that the resident requires intermittent encouragement and physical assistance, cueing to eat slowly and to monitor the resident every five minutes for choking however, the encouragement and assistance was not consistently provided throughout the lunch meal September 23, 2010.

4. An identified resident's plan of care indicates the resident is to receive two large nectar thickened fluids each meal however, the resident was only provided with one thickened fluid as observed during the lunch meal September 23, 2010.

5. An identified resident has a Physicians order for nectar thickened fluids however, the resident received Jello despite thickened fluid guidelines to avoid Jello.

6. An identified resident received tomato and cucumber salad despite specialized dietary guidelines that indicate the resident should not receive these menu items.

7. An identified resident's plan of care indicates they are to receive pureed soup at lunch, however the resident received regular soup at the lunch meal September 22, 2010. The resident had to ask staff to provide the correct texture.

8. An identified resident has a Physician's order for a specialized diet, however, the menu was not followed at the lunch meal September 23, 2010 and the resident received foods contrary to their menu plan for dessert.

9. An identified resident has a Physician's order for a specialized menu including a fluid restriction, however, they received items that were contraindicated on their menu plan at the lunch meal September 23, 2010. The resident was also offered more fluids than were stated on their fluid plan (985 ml of fluids were offered versus the planned 300ml at lunch meal).

10. An identified resident has an order for nectar thickened fluids, however, the resident was provided thin coffee at the lunch meal September 23, 2010. The resident stated they had some difficulty with the coffee and only 1/2 was taken. The resident was also given pureed fruit, however, their diet order is for minced texture.

11. An identified resident was provided tray service and was not offered an entrée despite documentation in the resident's plan of care to provide a puree diet. The resident was given pureed soup, dessert

and a nutritional supplement.

12. An identified resident was given their afternoon snack with their lunch meal. Staff stated this is required as part of the plan of care, however, there is nothing in the plan of care to indicate this is required. The resident is also to receive soup in dark mug, however, soup was given in a bowl at the lunch meal September 23, 2010.

13. An identified resident is to receive large portions, however, the resident received a regular portion at the lunch meal September 22, 1010.

14. An identified resident is to receive large beverage glasses, however, the resident received small glasses at the lunch meal September 23, 2010.

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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 with providing the care set out in the plan of care to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg. 79/10, s.71(1)(e)

Every licensee of a long-term care home shall ensure that the home's menu cycle, is approved by a registered dietitian who is a member of the staff of the home.

Findings:

1. There is no evidence that the current menu cycle has been approved by the home's Dietitian.

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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 with ensuring the menu cycle has been approved by the Home's Dietitian, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg. 79/10, s.73(2)(b)

The licensee shall ensure that, 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.

Findings:

1. An identified resident waited nineteen minutes with their soup placed in front of them prior to a staff member assisting the resident during the lunch meal September 23, 2010.
2. An identified resident requires total assistance with eating, however, the lunch meal September 22, 2010 was placed on the table prior to feeding assistance being available.

3. At the lunch meal September 23, 2010, two identified residents had their beverages placed in front of them prior to 11:50am and assistance was not provided until after 12:30pm. Both residents require total assistance with eating.

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WN #5: The Licensee has failed to comply with O.Reg. 79/10, s.71(4)

The licensee shall ensure that the planned menu items are offered and available at each meal and snack.

Findings:

The planned menu items were not offered and/or available at the lunch meals September 22, and 23, 2010 and the afternoon snack September 23, 2010.

1. The planned menu for the afternoon snack pass September 23, 2010 stated lemon pudding was to be provided for the pureed menu. Leftover mandarin chiffon from the lunch meal September 22, 2010 was served to residents, resulting in reduced variety.
2. The planned menu states pureed bread is served at all meals, however, this was not offered to residents requiring pureed menus at the lunch meal September 22, 2010 in two dining areas, resulting in reduced nutritional value of the meal.
3. The planned menu for the Gluten free pureed texture indicates mashed squash, however, diced squash was prepared.
4. The planned pureed menu items were not offered to an identified resident at the lunch meal September 23, 2010, resulting in an unusual combination of foods being served to the resident. The resident was provided pureed lasagna with mashed potatoes and gravy (gravy was spilling into the lasagna) instead of pureed lasagna with Caesar salad. The resident was unable to voice their meal preference and serving information did not indicate a preference for this choice.

Inspector ID #:	#165 and #107

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 with ensuring that the planned menu items are offered and available at eat meal and snack, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg. 79/10, s.72(3)(a)

The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,

(a) preserve taste, nutritive value, appearance and food quality.

Findings:

1. At the lunch meal September 22, 2010, the squash for the pureed gluten free menu was not prepared in a manner that preserves taste and food quality. The item was prepared cold (thawed from frozen) and kept on ice, however, it was planned to accompany hot menu items (roast chicken and mashed potatoes).

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WN #7: The Licensee has failed to comply with O.Reg. 79/10, s.73(1)4, 9

Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

4. **Monitoring of all residents during meals.**
9. **Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.**

Findings:

1. Ten residents were in the A3 dining room with fluids in-front of them and were left unsupervised at the lunch meal September 23, 2010.
2. An identified resident has a plan of care that requires a lip plate, however, the resident received a regular plate at the lunch meal September 23, 2010.
3. An identified resident has a plan of care that requires a sippy cup and utensil holder, however, the resident was given a large nosey cup and no utensil holders at the lunch meal September 23, 2010.

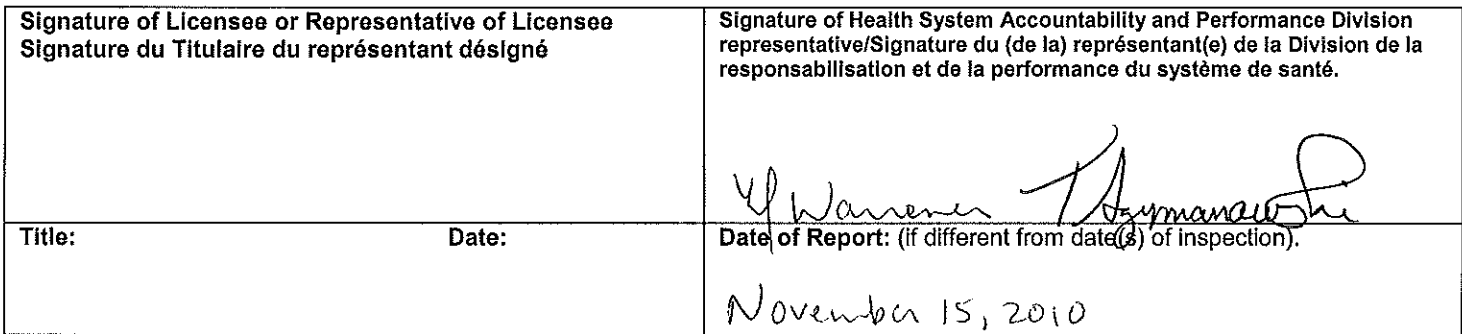
Inspector ID #: #107

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 with ensuring residents are monitored during meals and that any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possibly are provided to residents, to be implemented voluntarily.

CORRECTED NON-COMPLIANCE Non-respects à Corrigé				
REQUIREMENT EXIGENCE	TYPE OF ACTION/ORDER	ACTION/ ORDER #	INSPECTION REPORT #	INSPECTOR ID #
Homes for the Aged and Rest Homes Act, R.R.O. 1990, 637/5(m), related to P1.22 LTC Homes Program Manual			September 15, 22, 23, 29, 2009 Dietary Follow Up Report	
B3.25, LTC Homes Program Manual, now found in O.Reg. 79/10, s. 68.(2)(d)			September 2006	
P1.24, LTC Homes Program Manual, now found in O.Reg. 79/10, s. 73(1)8 and 10			September 2006, April 2007 Dietary reviews	
P1.4 , LTC Homes Program Manual, now found in O.Reg. 79/10 s.			September 2006, April 2007 Dietary reviews	

71(2)(b)				
M2.2, LTC Homes Program Manual, now found in the *LTC Homes Act, 2007,* S.O 2007, c. 8, s. 84			September 15, 22, 23, 29, 2009 Dietary Follow Up Report	



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.**
Title:	**Date:**	**Date of Report:** (if different from date(s) of inspection). November 15, 2010