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
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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
Nov 1, 2013	2013_202165_0020	L-000820-13	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

FOREST HEIGHTS
60 WESTHEIGHTS DRIVE, KITCHENER, ON, N2N-2A8

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

TAMMY SZYMANOWSKI (165)

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): October 25, 29, 2013

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Environmental Service Manager, the Food Service Manager, Dietary staff, Registered staff, Personal Support Workers, Laundry staff, Resident Service Co-Ordinator and residents

During the course of the inspection, the inspector(s) observation of meal service and production and review of policies and procedures

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry

Food Quality

Personal Support Services

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home's "Management of Concerns/Complaints" policy AD-C-40 was complied with.
A) The procedure for verbal concerns/complaints indicated that all employees would be instructed to report concerns/complaints to their immediate supervisor. The individual who was first aware of a concern would initiate the Resident Service Response form which would be forwarded to the Executive Director who would be responsible for the resolution of the concern. During resident interviews it was identified that one resident had raised concerns to the registered nursing staff regarding the response to call bells in the morning. One resident indicated that on five separate occasions they had waited 45 minutes to one hour for staff to respond to their call bell. This concern was not forwarded to their immediate supervisor and the Executive Director confirmed that they had not received a Resident Service Response form for this concern and it had not been investigated by the home. Call bell response times was a concern raised by other residents during resident interviews. [s. 8. (1)]

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 where the Act or this Regulation requires the licensee of a long term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) 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; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.
A) On October 29, 2013, the poached eggs served for the breakfast meal were observed to be hard, this was confirmed by the cook. Residents interviewed reported that it was very rare that they received soft poached eggs and confirmed the eggs served were hard. This concern was also raised by residents at the August 2, 2013, Food Council meeting. The pureed eggs were observed to be watery. The dietary aide confirmed that the puree eggs were always of that texture.
B) Several resident's interviewed indicated that meals were not served attractively and the appearance of the food was not appealing to eat. Residents reported that when gravy was used, it was poured over menu items in excess which ran into other food items on their plate. Residents reported that meat was often overcooked and really dry. Concerns regarding the cooking of meats was raised at the July 19, 2013, Food Council meeting. It was identified that when steak was served for a special occasion it was tough and rubbery.
C) Several residents raised concerns regarding the quality of food served including the meat quality. Residents also reported that they were denied being served seconds of bacon and coffee. The Food Service Manager confirmed that the homes food budget was under the allotted raw food cost allocated by the Ministry of Health for 2012, and was currently under the allotted raw food cost by the Ministry of Health for 2013.
D) The home has made several menu substitutions to the planned menu as a result of ingredients or food items not being available for production. It was noted that there were at least 11 menu items substituted over a three week period in October 2013. The Executive Director confirmed that not having sufficient ingredients/menu items in the home had been an issue for the production of quality foods. The taste and quality of vegetable soup was compromised on October 29, 2013. The cook confirmed that cabbage was not available for the preparation of the soup despite being listed on the home's vegetable soup recipe. [s. 72. (3) (a)]

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 all food and fluids in the food production system are prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that the home had a dining and snack service that included foods and fluids being served at a temperature that was both safe and palatable to the residents.
A) Several residents interviewed indicated that hot foods were often served "warm" compromising the palatability of foods. Temperatures taken by the inspector during the lunch meal October 25, 2013, revealed that the potato wedges were 55 degrees celsius. Residents interviewed stated that the potato wedges tasted cold. The temperature taken at the start of meal service for the egg salad sandwich was recorded by dietary staff at 7.6 degrees celsius. The Food Service Manager confirmed the product should be 4 degrees celsius or below. Temperatures taken during the breakfast meal October 29, 2013, by the inspector revealed that the pureed eggs were 52 degrees celsius. The dietary aide confirmed that temperatures of all menu items were not taken prior to the breakfast meal service. The home's Meals Service Daily Temperature Record was not always completed by staff and had several missing meal temperatures. This was acknowledged by the Food Service Manager. [s. 73. (1) 6.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that procedures were developed and implemented to ensure that there was a process to report and locate residents lost clothing and personal items.
A) Nursing staff interviewed indicated that when residents reported missing clothing that they would call down to the laundry department however; nursing staff did not complete any missing clothing checklist or document the missing articles of clothing. Laundry staff reported that nursing may call down when resident's clothing had gone missing however; they did not complete any missing clothing checklist or document the missing articles of clothing. There was no record kept by either department to identify when clothing had gone missing and there was no further investigation into the missing clothing items. The Resident Services Co-ordinator reported that a Client Service Response form was only completed if a family escalated their concerns.
B) Residents interviewed stated that they had several clothing items missing and that it had been reported to staff. Residents reported that staff responded by stating that the clothes would eventually turn up however; missing clothing articles had not been returned.
C) Observation of the laundry room revealed that there were at least two full racks and two full cardboard boxes of lost clothing. [s. 89. (1) (a) (iv)]

Issued on this 1st day of November, 2013

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

Tammy Szymanowski