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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 21, 2014 | 2014_190159_0027 | H-000481-14 | Complaint |

### Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE HALTON HILLS
9 Lindsay Court Georgetown ON L7G 6G9

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

ASHA SEHGAL (159)

### 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): November 17, and 18, 2014**

**During the course of the inspection, the inspector(s) spoke with residents, family members, registered and unregulated staff, the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Minimum data set/Point Click Care Coordinator and the dietary staff.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Laundry**
**Dining Observation**
**Personal Support Services**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 72. Food production**

**Specifically failed to comply with the following:**

**s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).**

**s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).**

**s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).**

**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 has failed to ensure that the food production system provided for standardized recipes for all menus.
Not all recipes were consistent with the quantities of the menu items specified on the production sheet report. The recipes were not scaled for the portions/servings required. On November 17, 2014, the lentil soup recipe used by the cook had yield 150 servings, however, the production sheet for week 1 Monday lunch had listed 128 servings (112 servings regular and 16 servings pureed soup). On November 18, 2014, the cook interview confirmed the Fall/Winter menus were recently implemented and all recipes were not adjusted. [s. 72. (2) (c)]

2. The licensee has failed to ensure that all menu substitutions are communicated to residents and staff.
On November 17, 2014, the daily menu posted on the unit (Terra Cotta)had listed butterscotch pudding for lunch dessert. The residents were served chiffon pudding. The menu substitution made was not communicated to residents and staff. The cook confirmed the butterscotch pudding was not available and the chiffon pudding was substituted, but the menu was not changed and communicated to residents. [s. 72. (2)

(f)]

3. The licensee has failed to ensure that the menu substitutions are documented on the production sheet.
On November 17, 2014, menu substitutions were made and the substitutions were not documented on the production sheet. Lemon chiffon pudding was served for lunch, the planned menu called for butterscotch pudding. The cook confirmed that the butterscotch pudding was not available, the lemon chiffon pudding was substituted but the menu substitutions were not recorded on the production sheet. [s. 72. (2) (g)]

4. The licensee has failed to ensure that all food and fluids are prepared, stored and served using methods that preserved taste, nutritive values, appearance and food quality. [O.Reg.79/10,s.72(3)(a).
On November 17, 2014, the food items served to residents at noon meal did not preserve the appearance, taste and quality. The meal served to residents did not appear to be appetizing and nutritious. The green beans were over cooked and soggy.
The lentil soup was very watery, the lentils were under cooked. The soup recipe had listed diced potatoes, carrots and celery to be used, the soup served to residents lacked vegetables. Residents interviewed voiced their concerns regarding the quality of food served. There was a high plate waste, and it was noted many residents had not eaten soup.
The spinach Onion with vinaigrette (Spinach salad) recipe was not followed. The vinaigrette salad dressing was not prepared, a purchased product was served. The spinach salad recipe called for red onions, the cook confirmed that the red onions were not ordered and white onions were substituted. Inconsistency in use of ingredients listed in recipes not only compromised the taste, but also the quality and nutritive value. [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 ensuring that the food production system provided for standardized recipes for all menu.[O.Reg.79/10,s.72(2)(c)],all menu substitutions are communicated to residents and staff. [O.Reg.79/10,s.72(2)(f)], the menu substitutions are documented on the production sheet.[O.Reg.79/10,s. 72 (2)(g)], all food and fluids are prepared, stored and served using methods that preserved taste, nutritive values, appearance and food quality. [O.Reg.79/10,s.72(3)(a)], to be implemented voluntarily.***

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**WN #2: 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).**

**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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the food and fluids served are at temperature that is both safe and palatable.

During the observed meal on November 17, 2014, hot food temperatures were found to be in the unsafe temperature zone at the point of service. Meal service was observed in the (Terra Cotta) dining room at 1200 hours. At approximately 1210 hours, the inspector tested the temperature of certain food items at the service point. The hot food items were in the hot food cart and were probed at soup 130 degree Farenheight , pureed pork at 120 degree Farenheight, green beans 85.5 degree Farenheight and mince pork at 110.5 degree Farenheight. Hot and cold food not served at safe temperatures compromises palatability, reduces food intake and also increases risk for contamination. [s. 73. (1) 6.]

2.The licensee has failed to ensure that proper techniques are used to assist residents with eating including safe positioning of residents who require assistance.
November 2014, resident #1 was noted being fed by staff while their head leaned to the right side. The resident was not positioned in an upright position. The plan of care for resident #1 indicated they were to be positioned upright at 60-90 degrees at meals and snacks, and stay upright for at least 15-20 minutes after eating/drinking.
The Registered Practical Nurse confirmed resident should have been repositioned prior to meal in an upright position. The plan of care had identified this resident was at risk for choking due to dysphagia and eating difficulty.

November 2014, resident #2 was observed in the dining room at lunch being fed in a reclined position in resident's chair. The resident was noted sliding down in their chair and had their head leaned to the right side while being fed, creating a risk for choking. The plan of care for the resident indicated for safety risk factor staff was to place small pillow (cover with pillow case) right side for positioning while resident in a wheel chair. When the inspector spoke with the Personal Support Worker (PSW) they indicated they were not aware that a pillow was to be placed for positioning and that the resident was to be positioned in an upright position for meals and snacks. Registered staff confirmed the resident was not safely positioned during the meal and the resident was repositioned. [s. 73. (1) 10.]

***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 the food and fluids served are at temperature that is both safe and palatable.[O.Reg.79/10,s.73(1)(6)]***
***Ensuring that ensure that proper techniques are used to assist residents with eating including safe positioning of residents who require assistance [O.Reg.79/10,s.73(1)10., to be implemented voluntarily.***

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**WN #3: 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,**
**(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).**

**Findings/Faits saillants :**

1. The licensee had failed to ensure that a sufficient supply of clean linens, face cloths and bath towels were available in the home for use by residents.
On November 17, 2014 at approximately 1435 hours the inspector in the presence of a PSW checked the clean linen supply on the unit (Terra Cotta). The PSW confirmed there was no clean linen supply for residents' use and the linen cart was empty. The PSW reported that the clean linen supply was to be delivered in the afternoon before 1500 hours. At 1450 hours the laundry staff was observed delivering the clean linen supply on the unit. The inspector checked the delivery of the clean linen supply and found there were only twenty face cloths brought on the linen cart. The PSW reported there was not a sufficient supply of face cloths for twenty five residents on this unit, and there was always a short supply of face cloths and bath towels.
Three Staff and four residents interviewed during the course of the inspection identified concerns with the short supply of linen, identifying at time when there were no face cloths, paper towels were used. The Assistant Director of care confirmed that paper towels were used when there is a short supply of face cloths.
Interview with the Administrator and the Assistant Director of Care acknowledged an awareness of concerns related to short supply of face cloths. [s. 89. (1) (b)]

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**Issued on this 21st day of November, 2014**

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

**Original report signed by the inspector.**