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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
Jun 2, 2014	2014_344586_0003	H-000945-13	Complaint

Licensee/Titulaire de permis

KING NURSING HOME LIMITED
49 Sterne Street, Bolton, ON, L7E-1B9

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

KING NURSING HOME
49 Sterne Street, Bolton, ON, L7E-1B9

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

JESSICA PALADINO (586), 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): May 13, 14, 2014.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Food Service Manager (FSM), Registered Dietitian (RD), Registered Staff, Personal Support Workers (PSW), Dietary Staff, and residents.

During the course of the inspection, the inspector(s) reviewed resident health records, production reports, Resident Food Committee Meeting minutes, complaint logs, recipe binder, and menus; Observed meal service and nourishment pass.

The following Inspection Protocols were used during this inspection:
Dining Observation
Nutrition and Hydration

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

Specifically failed to comply with the following:

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).

s. 6. (10) 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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the following residents as specified in the plan.

A) Resident #0001's care plan stated the resident is to receive a nutrition intervention during afternoon snack pass ordered by the Registered Dietitian (RD). The resident was identified to have a low body mass index (BMI) and poor oral intake. A dietary progress note documented by the RD dated September 4, 2013 identified that the Power of Attorney (POA) had requested the resident to receive this intervention at afternoon snack as it is one of the resident's favourite foods. On May 13, 2014, observation of afternoon snack pass at 1445 hours to 1530 hours confirmed resident was not offered the ordered intervention as an afternoon snack. The Personal Support Worker (PSW) served the resident ginger ale and cookies. Interview with three PSWs confirmed that there were no labelled special snacks during afternoon snack pass, excepting for one resident who received juice. The resident did not receive afternoon snack as specified in the plan of care.
B) Resident #0002's care plan and physician's order stated the resident is to receive a texture-modified diet. At lunch service on May 13, 2014, resident was served the incorrect textured diet. Resident was observed having difficulty scooping the food onto spoon as the food consistency was very thin. The resident only consumed less than one third of the meal served. On May 14, 2014, interview by Inspector #159 with the RD, PSW, and dietary staff confirmed resident did not receive correct diet on May 13, 2014. [s. 6. (7)]

2. The resident did not have their plan of care revised when the care set out in the plan of care had not been effective in relation to weight loss, poor oral intake and abnormal laboratory results.

Resident #0001's food and fluid intake records were reviewed for April 2014. The intake records indicated resident was eating poorly, most days refusing breakfast, consuming most noon and evening meals 25-50 % and also was refusing afternoon and evening nourishment. This was supported by the progress notes and the staff interviewed. The food and fluid intake record confirmed resident was not meeting their nutritional requirements assessed by the Registered Dietitian and documented in the plan of care. The plan was to continue with the nutritional care plan, with the same interventions, which were not effective related to poor oral intake, low body weight and abnormal laboratory values [s. 6. (10) (c)]

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 the care set out in the plan of care is provided to the residents as specified in the plan (s. 6. (7)); and to ensure that the residents have their plan of care revised when the care set out in the plan of care has not been effective (s. 6. (10) (c)), 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 failed to 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 May 13, 2014, review of the production report and interview with the cook confirmed they prepared 85 servings of cream of tomato soup. The Food Services Manager (FSM) confirmed the home presently had 86 residents total. However, review of the cream of tomato soup recipe revealed there was a maximum yield of 57 servings, therefore the recipe was not scaled for the number of servings the home required.
B) Recipes for Spanish omelet, pureed menu items and beet and onion salad were not followed. The recipe for the Spanish omelet stated liquid eggs were to be used, however observation on May 13, 2014 and confirmation by the cook revealed fresh eggs were used. The cook was unsure how many eggs the recipe called for. Ingredients were substituted for beet and onion salad, i.e. white onions were used where the recipe called for red onions. The beet salad was to be served on a bed of leaf lettuce, however this was not done until Inspector #159 made the FSM aware of the recipe. When informed of this by the FSM, the cook confirmed they were

unaware. Recipes were not followed to ensure quality and consistency.
C) Food items were prepared too far in advance of meal service. On May 13, 2014, the cook confirmed due to lack of oven space, the minced and puree omelets were prepared at 1045 hours to be served at 1200 hours. The omelet served at lunch appeared dry and rubbery. Food items were prepared too far in advance resulting in reduced nutritive value, appearance and food quality.
D) On May 13, 2014, the consistencies of the pureed omelet, pureed hash browns and pureed beets were very thin. The consistency of the pureed items was more of soup when scooped at the serving cart. The recipes stated ingredients should be blended until pudding-like consistency. The lunch meal served to resident #0002, which consisted of pureed cheese, bread, and beets, was noted to be runny on the plate, causing thin liquid to disperse throughout the plate. The food was not eye-appealing, and the quality and taste was compromised. Due to inconsistent textures, there was an increased risk of choking. The resident was observed coughing while feeding themselves during service. They were also observed having difficulty scooping the thin food with their spoon, which resulted in the resident leaving the dining room having only consumed less than 25% of their meal.
E) On May 14, 2014, the pureed bread was observed to be very thin and poured out like soup when scooped at the serving cart. Observed a resident with pureed bread that was thin and running all over the plate. The consistency of the pureed items was inappropriate, affecting the taste, nutritive value, appearance and food quality. [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.

Issued on this 3rd day of June, 2014

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