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
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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
Oct 14, 17, Nov 3, 4, 15, Dec 21, 2011	2011_066107_0011	Follow up

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

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

SHERIDAN VILLA
2460 TRUSCOTT DRIVE, MISSISSAUGA, ON, L5J-3Z8

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

MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Registered Dietitian, Food Service Supervisor, nursing and dietary staff and residents.

During the course of the inspection, the inspector(s) Toured the home, observed meal service on one floor, reviewed an identified resident's clinical health record, observed food preparation, and reviewed relevant policies, related to inspection H-002065-11.

The following Inspection Protocols were used during this inspection:

Dining Observation

Food Quality

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
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).

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

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)]
The licensee did not ensure that the care set out in the plan of care was provided to several residents at the lunch meal October 14, 2011:
a) Three identified residents had a plan of care that instructed staff to provide specific items at meals, however, the residents did not receive these items.
b) An identified resident had a plan of care that instructed staff not to provide specific items at meals, however, the resident received the items.
c) An identified resident had a plan of care that instructed staff to provide their meal in a specific manner, however, this was not done.
d) An identified resident had a plan of care that instructed staff to provide
regular fluids and that the resident dislikes milk. The resident was provided thickened milk and water.
e) Two identified residents had a plan of care that instructed staff to provide a certain consistency of thickened fluids, however, the residents received the wrong consistency of thickened fluids.

Staff interviewed confirmed the items were not provided according to the residents' plans of care.

2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(c)]
The licensee did not ensure that the plan of care for an identified resident was reviewed and revised when the care set out in the plan was not effective in relation to weight loss and poor hydration.
The resident's plan of care identified a goal to minimize further weight loss, however, when the resident experienced further significant weight loss, interventions on the plan of care were not revised, nor was the goal for the prevention of weight loss revised.
The resident's plan of care identified a goal for a minimum fluid intake per day. The resident was consistently consuming less than their fluid goal (all days reviewed, however, the nutritional plan of care was not revised to include strategies to improve the resident's hydration.

3. [LTCHA, 2007, S.O. 2007, c.8, s. 6(4)(a)]
Staff and others involved in the different aspects of care did not collaborate with each other in the assessment of an identified resident's hydration status, so that their assessments were integrated, consistent with and complemented each other.
The coding on two Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessments completed by nursing staff in 2011 did not identify the resident was drinking poorly with insufficient hydration. Progress notes, food and fluid intake records, and assessments by the Registered Dietitian identify that the resident was drinking poorly and not meeting hydration goals. The Dehydration Resident Assessment Protocol (RAP) was not triggered and assessed due to the discrepancies and inaccurate coding in the RAI-MDS assessments.

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 section 6(7), 6(10)(c), and 6(4)(a), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 69]
The licensee did not ensure that actions were taken and outcomes were evaluated when an identified resident experienced a 10.2% significant weight loss over six months, identified in 2011. The resident had a plan of care that identified a goal to prevent further weight loss, however, after the significant weight loss (progressive decline in nutritional intake, hydration and weight) the plan was to continue with the same interventions as per the nutrition care plan. Action was not taken to prevent further weight loss.

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 residents with significant weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 71(4)]
Residents receiving a specific menu at the lunch meal October 14, 2011 were not offered all of the planned menu items. The planned menu included a whole wheat roll. This was not offered to residents at the meal. Residents receiving the first choice meal did not receive a serving of grains with the meal, resulting in reduced nutritive value of the meal.

Two identified residents were not offered a choice of beverage, as identified on the planned menu, at the lunch meal October 14, 2011. One resident was offered only a supplement and the other was offered only water.

Mousse was prepared as an alternative dessert for residents who required thickened fluids at the lunch meal October 14, 2011. The planned menu specifies diet and regular mousse were to be prepared, however, the same type of pudding was made for everyone (regular, as per staff).

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 each meal and snack, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

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
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. [O.Reg. 72(3)(a)]
Not all foods were prepared, stored and served using methods that preserve taste nutritive value, appearance and food quality.
a) Ice cream stored in the first floor servery was in the "freezer" which was being used as a refrigerator. The temperature of the refrigerator was 28-37 degrees Fahrenheit. The ice cream was melted and the method of storage did not preserve taste, appearance and food quality.
b) The current system for serving the pureed menu did not preserve taste, appearance and food quality and did not provide the same level of quality as the regular textured menu. Items on the pureed menu were prepared the day prior to service (regular textured menus were prepared day of service). The items were pre-portioned into small containers, however, the containers were not of adequate size to preserve the appearance of the meal as items were stacked on top of each other in the dish. Brown gravy was placed over top of the pureed meal (fish), however, the regular textured menu was served tartar sauce. Staff interviewed stated the pureed items were prepared this way as it was easier for staff.
c) Sandwiches prepared for the lunch meal October 17, 2011 were not prepared using methods which preserve nutritive value. The recipe for the sandwiches specified a #10 scoop for the filling, however, the sandwiches were prepared with a #16 scoop filling (smaller).
d)Penne pasta was prepared and then cooled on Friday for the Saturday supper meal. The recipe indicated preparation of the pasta the day it would be served and to simmer in broth. The pasta was cooked with water. The recipe for penne pasta (Saturday supper) included fresh mushrooms, however, these were not ordered and canned were substituted (as per staff). This will affect the taste and quality of the meal.

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 all food and fluid 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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
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.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 73(1)10]
Not all residents who required assistance with eating were fed using proper techniques at the lunch meal October 14, 2011.
a) An identified resident was not positioned safely at the meal. The resident's head was falling to the side, their chin was not tucked, and the positioning aide was slipping and was not repositioned. Staff feeding the resident were standing to feed the resident.
b) Staff assisting an identified resident with eating did not allow sufficient time for the resident to swallow between bites and were attempting to put more food into the resident's mouth when they had not yet swallowed. The resident kept moving their head away from the spoon/glass until they had swallowed, however, staff did not identify these cues.

2. [O.Reg. 79/10, s. 73(1)11]
Appropriate seating for staff that are assisting residents to eat was not available in the dining room at the lunch meal October 14, 2011. Staff were using dining room chairs when they were assisting residents with eating, however, the seating was not adjustable and could not be positioned to accommodate residents in large wheelchairs or residents of varying heights. Staff were observed standing to feed residents and feeding residents while they were not at eye level, creating poor positioning of the residents and a risk for choking.

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 proper techniques to assist residents with eating, including safe positioning of residents who require assistance and appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat, to be implemented voluntarily.

WN #6: 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 saillants :

1. [O.Reg. 79/10, s. 26(4)]
The Registered Dietitian, who is a member of the staff of the home, did not complete an assessment of an identified resident when there was a significant change in the resident's skin integrity (two new open areas) identified by nursing. Skin integrity was not assessed by the Registered Dietitian until almost two months after the change in skin integrity when the resident experienced a significant weight loss.

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 registered dietitian who is a member of the staff of the home completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and assesses the matters referred to in paragraphs 13 and 14 of subsection (3), to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 30(2)]
The licensee did not ensure that actions taken with respect to an identified resident's care under the nursing and personal care program, were documented. The resident choked at a meal service, however, documentation does not include any mention of this choking incident until noted by the Registered Dietitian four days later. An assessment of the choking incident, interventions provided while the resident was choking and the resident's response to the interventions was not documented.

WN #8: 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 8(1)]
The licensee of the home did not ensure that the skin and wound care program policy was complied with.
The policy states the Registered Dietitian is to complete a nutritional and hydration risk assessment on Point Click Care (PCC) within 7 days and assesses the resident monthly at a minimum, and more often if requested by Nursing.
This policy was not followed for an identified resident after a change in skin integrity. The resident's nutritional status in relation to skin integrity was not assessed by the Registered Dietitian until two months after the change in skin integrity.

Issued on this 23rd day of December, 2011

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