Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
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Original Public Report

Report Issue Date: September 5, 2023	
Inspection Number: 2023-1386-0003	
Inspection Type: Complaint	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Taunton Mills, Whitby	
Lead Inspector Diane Brown (110)	**Inspector Digital Signature** Diane Brown Digitally signed by Diane Brown Date: 2023.09.22 11:01:32 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 16-18, 21-23, 2023

The following complaint intake was inspected:

- Intake related to concerns with food production, menu planning, plan of care and the offering of meals.

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Food Production

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (d)

The licensee failed to ensure that the food production system provided for the preparation of all menu items including for those items on individualized menus.

Summary and Rationale

A complaint was made to the Director with concerns related to the food service program.

A posted individualized menu for resident #001 was observed. A Meal Service Report directed Food Service Aides (FSA) to refer to this menu when serving the resident. During a mealtime, the resident's menu required an item to be served along with their entrée. The menu item was not served and FSA #103 plating the meal confirmed it was not available. An alternative item was provided.

Failing to prepare and serve menu items according to the resident's individualized menu may impact the goal to promote the resident's health and well-being.

Sources: Observations, resident #001's individualized menu, Meal Service Report and an interview with Food Service Aide #103. [110]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)

The licensee failed to ensure the monitoring of resident #001's food intake, who was identified at nutritional risk.

Summary and Rationale

A complaint was made to the Director with concerns that resident #001 had not been offered a meal however documentation revealed that the resident had eaten.

The homes' system of monitoring a resident's food intake was identified in the "Nutrition and Hydration" policy, #07-24, that required PCA's to enter food intake into an electronic documentation

system. PCA's were to document food that they could visually verify the resident had consumed and to collaborate with other PCA's to ensure accurate documentation of all resident's intake.

Resident #001 was not offered a meal on an identified day as confirmed by the Director of Care and an Incident Summary Report. Electronic documentation, on this meal, revealed the resident consumed 51-75 percent (%). PCA #100 who documented had not visually verified that the resident consumed the meal but was told by another PCA that the resident had eaten and in what amount. PCA #100 could not recall the name of the PCA who reported the resident had eaten. The DOC later corrected the resident's meal intake to reflect zero food taken following the results of an investigation.

Failure to accurately represent the resident's food intake could impact an accurate assessment of the resident.

Sources: Nutritional Care policy titled "Nutrition and Hydration", policy #07-24, last approved March 15, 2023. Dietary Intake Report. Incident Summary report, resident's health record and interviews with PCA #100 and DOC. [110]

WRITTEN NOTIFICATION: Menu Planning

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (a)

The licensee failed to ensure that resident #001 was offered a minimum of three meals daily.

Summary and Rationale

A complaint was made to the Director with concerns that resident #001 had not been offered a meal on an identified day.

A progress note entered by RPN #102 and an 'Incident Summary Report' completed by the Assistant General Manager confirmed resident #001 had not been offered a meal on an identified day. Interviews with PCA #101, RPN #102, FSA #103 and the Food Service Manager also confirmed that the resident had not been offered a meal on this day.

Failing to provide a meal to resident #001, who was unable to express their needs, may have left the resident hungry until a snack was provided.

Sources: Resident #001's health record and Incident Summary report, interviews with PSW #101, RPN #102, FSA #103 and Food Service Manager #106. [110]

WRITTEN NOTIFICATION: Food Production

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (c)

The licensee failed to ensure the homes' food production system provided production sheets for all menus including resident #001's individualized menu items.

Summary and Rationale

A complaint was made to the Director with concerns related to the food service program.

During a meal observation, resident #001 did not receive a menu item according to their planned menu. FSA #103 confirmed it was not available to be served. Review of the dinner food production sheets, along with the Director of Hospitality, revealed the absence of this menu item. A further review of the production sheets revealed the absence of another menu item that was planned for lunch on Tuesday of week two's menu cycle.

Food Service Manager acknowledged the missing food item at the meal observed, and the requirement to ensure all menu items are included on the home's food production sheets.

Failing to prepare and serve menu items according to the resident's individualized menu may impact the goal to promote the resident's health and well-being.

Sources: Observations, the planned menu for resident #001, food production sheets, and interviews with Food Service Aide #103, Director of Hospitality and Food Service Manager. [110]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.

The licensee failed to ensure that the home has a dining and snack service that includes a process to ensure that food service workers and other staff assisting resident #001 were aware of the residents' diet, special needs and preferences.

Summary and Rationale

A complaint was made to the Director with concerns related to the food service program.

The homes' process to ensure that food service workers were aware of resident #001's diet, special needs and preferences was by-way-of an electronic Meal Service Report available on a monitor in the servery for staff reference when serving.

A review of the Meal Service report for resident #001 included the resident's diet, dislikes, items to not service along with a daily note to refer to the resident's specialized menu posted.

A review of the resident's plan of care in the resident's health record identified dietary special needs and interventions. These special needs were not communicated to food service workers through the Meal Service Report or the resident's specialized menu.

Observations made at two meals, revealed the resident's special needs were not provided as FSA #103 was unaware. Food Service Manager #106 acknowledged the gap in transcribing dietary interventions from the resident's care plan into the Meal Service Report available to food service workers. Further, a portion size adjustment intervention was located in an area of the Meal Service Report not viewed by the FSA when demonstrating the report to the Inspector. The FSA was unaware of the portion size adjustment for a food item and the item serving size was not adjusted at the meals observed.

Failing to ensure food service workers were aware of resident #001's special dietary needs placed the resident at risk of their nutritional needs not being met and unplanned weight loss.

Sources: Observations. Meal Service Report, resident's health record, plan of care and interviews with FSA #103 and Food Service Manager. [110]