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
Oct 16, 2013	2013_190159_0028	H-000555-13	Complaint

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

MALTON VILLAGE LONG TERM CARE CENTRE
7075 Rexwood Road, MISSISSAUGA, ON, L4T-4M1

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

ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 7, 8, 2013

During the course of the inspection, the inspector(s) spoke with administrator, Food Service Manager, Registered Dietitian, registered staff, personal support worker staff, dietary staff and the residents.

During the course of the inspection, the inspector(s) reviewed clinical health records for identified residents, policies and procedures of the home, menus, food production reports. Observed part of the food production process, meal service in two home areas.

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	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 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. A) Not all food and fluids were prepared, stored and served using methods that preserved taste, nutritive values, appearance and food quality.
On October 7, 2013, the food items served to residents at noon meal did not preserve the quality. The cook indicated that the process of preparing the mince and puree textured food items was to cook and panned before 10:30 hours and then held in the oven until the noon meal serving time. The cook also indicated that the process of preparing mince and puree vegetable was to thaw frozen vegetables a day in advance, the uncooked vegetables were pureed and minced and then held in the oven until the serving time(over 2 hours before the service. During the observed lunch meal on October 7, 2013, in Yorkshire and McKchnie dining area, the vegetarian entrée, the pureed and minced hamburger held in hot food cart had black caking on the top, appeared dried out resulting in compromised food quality. The preparation of minced and pureed foods too far in advance of the meal being served decreased the food quality by changing the food characteristics including the appearance, texture, and flavour of the food. The nutritive value of the food was decreased by holding the prepared food in the ovens over extended period before the meal service.
B) Not all recipes were consistently followed. The recipes for Tossed Lettuce Salad indicated the following ingredients: Lettuce, Iceberg, Lettuce Green leaf, Lettuce Romaine, Carrots, Fresh Whole (shredded) and Italian dressing. On October 7, 2013, the chopped iceberg lettuce served to residents for lunch did not include all the ingredients i.e. green leaf and romaine lettuce, and fresh shredded carrots specified in the recipe were omitted. The Food Service Manager confirmed some ingredients were not in stock and the staff did not follow the tossed salad recipe.
C) The food production report did not include all special menu items required to be prepared for residents who needed individualized food substitution due to intolerance and/or allergy to certain foods. [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 all food and fluids in the food production system are prepared, stored and served using methods to preserve nutritive value, appearance and food quality, to be implemented voluntarily.

WN #2: 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. (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 plan of care for resident #00002 was not revised when their care needs changed in relation to nutritional care needs. The progress notes dated August 2013 documented by the registered dietitian indicated resident at high nutritional risk due to a significant undesirable weight loss in three months, secondary to poor intake. However, the current plan of care under the focus nutritional risk identified to promote gradual weight loss to goal weight range recommended by the Registered Dietitian. The monthly weight recorded for September 2013 was below the goal weight range recommended by the registered dietitian.[s.6.(10)(b)]

WN #3: 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. Staff in the home did not comply with the following policies and procedures related to monthly weight record:
Staff in the home did not comply with the home's weight monitoring System Program. The weight record policy identified as # LTC4-05.16.05 dated April 2011, direct staff "the resident will be re-weighed on the same shift if there is a weight variance and record the weight in the monthly record's re-weigh column, the registered nursing staff will verify the re-weigh. Enter only re-weigh on the electronic documentation system if re-weigh has occurred." The staff and the clinical electronic documentation i.e. monthly weight record confirmed that staff did not comply with these directions in the care for resident # 00001, resident # 00002, and resident # 00003 when variances in weights were identified.
The resident #00001's monthly weight recorded for July 2013 and August 2013 indicated a significant weight change over one month. The Administrator and the Registered Dietitian confirmed that the staff did not reconfirm weight variances as per home's weight monitoring program.
Resident #00002's monthly weight record for June 2013 and July 2013 indicated a significant weight variance over one month. The electronic weight record and the staff confirmed the resident was not re-weighed and the weight variance was not reconfirmed.
Resident #00003's a variance in monthly weight was not reconfirm. The monthly weight recorded for August 2013 and for September 2013 indicated unplanned weight changes over one month. The Administrator and the Registered Dietitian confirmed a re-weigh to verify the accuracy of the weight did not occur. [s. 8. (1) (b)]

Issued on this 21st day of October, 2013

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