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

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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
Nov 26, 2012	2012_108110_0025	T-137-12	Complaint

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

THE WESTBURY
495 The West Mall, ETOBICOKE, ON, M9C-5S3

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

DIANE BROWN (110), VALERIE JOHNSTON (202)

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): int inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Dietitian (RD), Continuous Quality Improvement Co-ordinator, Staff Educator, Registered Nursing Staff, Food Service Supervisor, Assistant Food Service Supervisor, Cook, Food Service Workers, Personal Support Workers (PSW's),Staff at Community Care Access Centre (CCAC) residents.

During the course of the inspection, the inspector(s) Monitored food preparation of a lunch meal, observed provision of care for residents, observed meal service, reviewed clinical records and relevant polices and procedures.

This inspection reflects LOG #'s T-137-12 and T-00671-12

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Dignity, Choice and Privacy

Food Quality

Nutrition and Hydration

Personal Support Services

Safe and Secure Home

Sufficient Staffing

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. (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 2007, c. 8, s. 6 (4).
(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).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that different aspects of care are integrated and are consistent with the compliment each other,
Resident #001 was identified as using an individualized "Daily Fluid Balance Flow Sheet" initiated by the physician and Power of Attorney (POA) to monitor resident #001's fluid intake and pulse. The fluids documented represented an accurate, actual intake of resident 2's oral fluid intake according to the residents' POA who provides total care to Resident 2 for eating and drinking.
The Personal Support Workers (PSW's)continued to document fluid intake on the "Daily Food and Fluid Intake Record". The two records of fluid intake for same time period show discrepancies. A Registered Staff interview stated that the PWS's record of Resident 2's fluid intake is inaccurate as it represents what is offered to resident and not what has been taken. The home's RD was not aware that resident 2's "Daily Fluid Balance Flow Sheet" completed by the POA was a record of resident 2's total fluid intake. The RD considered the PSW intake sheets as part of her nutritional assessment of Resident 2 which represented a higher fluid intake. On two occasions September 29th-Oct. 3rd, 2012 and October 21st- 26th, 2012 Resident 2's fluid intake was documented by the POA to be less than 1000mls on the "Daily Food and Fluid Intake Record" . No referral to RD was communicated. Resident was ordered IV hydration for 3 days on October 26th, 2012. [s. 6.(4)(b)] [s. 6. (4) (b)]

2. Resident #005 had requested 250ml prune juice daily. Resident #005's plan of care stated "250 ml Prune Juice as per individual portion as per likes". Resident interviewed and identified that sometimes this resident gets prune juice and sometimes doesn't. Resident stated that Friday November 1st he/she received only 125mls prune juice at breakfast but Thursday November 2nd was provided 250ml prune juice at breakfast and told to have another 250mls of prune juice at morning snack.
The Food Service Supervisor (FSS) identified that 250mls of prune juice shows up in error twice for Resident #005 once on the "Tray Ticket notes" at breakfast and is also on the "Snacks and Extras" sheet at am snack.
The FSS confirmed that Resident #005 should only receive 250ml prune juice once a day. [s. 6. (7)] [s. 6. (7)]

3. Resident #003's plan of care requires her to be served 250mls CIB three times a day at meals. Resident's plan of care also states "Do Not Serve Foods" which

included oatmeal cereal. At breakfast on November 2nd, 2012 resident was not served 250mls of CIB and was served an oatmeal/quinoa cereal. The Food Service Worker serving was interviewed and did not identify Resident #003 as requiring CIB shakes. This intervention was initiated and ongoing since December 12th, 2011 according to residents' plan of care. [s.6.(7)] [s. 6. (7)]

4. Resident#004's plan of care requires resident to receive 125mls CIB shake at breakfast as identified on the Dining Serving Report. November 2nd, 2012 resident was observed at breakfast and did not receive a CIB shake.[s.6.(7)] [s. 6. (7)]

5. Resident #002 has a plan of care to provide 250mls Carnation Instant Breakfast (CIB) shake at breakfast and 125mls at lunch and dinner based on the Registered Dietitian's assessment of October 11, 2012. On November 2nd, 2012 Resident #002 was observed by inspector and did not receive a CIB shake at breakfast.
The Food Service Worker interviewed was not aware of Resident #002's need for CIB shakes and CIB shakes were not identified on the Dining Serving Report.
An interview with the Assistant Food Service Supervisor confirmed that this intervention was overlooked and not transcribed from the Dietitian visit record of October 11th, 2012 to the homes' Dining Serving Record for staff.
The Dining Serving Report states for Resident #002 "Do Not Serve Groups" which includes "bread, wheat x sndw". Resident #002 was served pureed bread at breakfast November 2nd, 2012.[s. 6.(7)] [s. 6. (7)]

6. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
Resident #006 has a plan of care to "avoid nuts, seeds, gassy vegetables" and was served a mixture of vegetables November 1st, 2012 at lunch. The vegetables served were considered "gassy vegetables" according to the Assistant Food Service Supervisor and should not have been served to this resident.
The Food Service Worker serving meals referred to other vegetables as "gassy vegetables" not those that had been served to Resident #006.[s.6.(7)] [s. 6. (7)]

7. The licensee failed to ensure that the care set out in the plan is provided to the resident as specific in the plan. Resident #001's need for IV hydration for 3 days was not provided.
Resident #001 identified as a hydration risk was ordered by the physician on October 26, 2012 to receive

intravenous therapy 2/3 + 1/3 @75 cc hour for 3 days. Clinical record and staff interviews revealed
that on October 27, 2012 at an unspecified time, CCAC initiated the intravenous therapy. On October 29, 2012 the intravenous therapy was stopped and re-initiated on October 29, 2012 at 0945 hours by CCAC staff. On October 30, 2012 at 0600 hours the intravenous therapy was found to be stopped again and reordered by the physician to continue for another 3 days due to the periodic stops and unknown quantity of hydration infused.[s.6.(7)] [s. 6. (7)]

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 nutritional care set out in the plan of care is provided to residents as specified in the plan., 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. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; 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 did not ensure that the menu items were prepared according to the planned menu on October 31st, 2012 and November 1st, 2012.
The planned menu including recipes were not followed as observed:
Chicken salad croissant sandwiches included relish in the prepared product. The recipe did not include relish in the ingredient list.
Pureed corn chowder soup included the use of thickener. The recipe did not include thickener in the ingredient list.
Frozen vegetables were panned and defrosting in the fridge hours prior to steaming. Manufacturer directions state "do not thaw vegetables before cooking. If thawed cook immediately".
Frozen cod nuggets were panned and defrosting in the fridge at 0945h for lunch. The standardized recipe requires manufacturer directions to be followed. Manufacturer directions stated "keep frozen until used; place frozen nuggets on baking pan in preheated oven".
Frozen Mexican blend vegetables were steamed and panned for service. Recipe called for margarine and dried parsley to be added. The ingredients were not included.
Cheese and Fruit salad plate recipe called for green leaf lettuce with fruit on top. Lettuce was not served.
Pureed scones were prepared with an unmeasured amount of water. The recipe called for margarine and a specific volume of milk to be added.
Cottage cheese was pureed with an unmeasured amount of water. An unmeasured amount of thickening product was added as cook stated too much water had been added. Recipe did not require water or thickener to be added.
The Cream of wheat cereal recipe calls for salt to be added. Cook confirmed that salt is not added.
Resident interviews revealed that food is often bland and lacks flavour.[r. 72.(2)(d)] [s. 72. (2) (d)]

2. The licensee did not ensure that foods are prepared, stored and served using methods which preserve taste, nutritive value, appearance and food quality.
The preparation of a lunch meal was monitored on October 31st, 2012.
In the kitchen, at approximately 1000h on October 31st, 2012 breaded cod nuggets and potato coins (fries) were steamed cooked and observed being placed in the hot holding unit. At approximately 1130h the steamed breaded cod nuggets were removed from the holding unit and pureed with an unmeasured amount of water. The same practice was observed for the steamed potato coins. These preparation

methods of steaming frozen products instead of oven baking then hot holding for 1.5 hours and pureeing with an unmeasured amount of water were all contrary to the standardized recipes and established practices according to the Food Service Manager. An interview with the Food Service Manager confirmed that staff are to follow standardized recipes which would have required the cod nuggets and potato coins to have been oven baked; cod nuggets would have been pureed with a measured volume of chicken soup base and potato coins with milk. The FSM stated products should not have been hot held in advance of texture modifying.
Interview with families whose residents receive pureed foods revealed that pureed food is unacceptable in taste.
Preparation practices observed negatively impacted on taste, nutritive value, appearance and food quality.[r.72.-(3) (a)] [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 the menu items are prepared according to the planned menu to preserve taste, nutritive value,appearance and food quality., to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has not ensured that foods are served at temperatures palatable to the residents.
On October 7th, 2012 towards the end of meal service at 1248h hot vegetables were probed at 46 degree Celcius. Residents continued to be served after hot vegetables were probed. The Food Service Manager confirmed through interview that the serving temperature standard is 60 degree Celcius. Resident interviews revealed that hot food is not always served hot enough including the vegetables.[r. 73. (1) 6.] [s. 73. (1) 6.]

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 hot foods are served at temperatures palatable to residents., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 218. Orientation
For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Findings/Faits saillants :

1. The licensee failed to ensure that additional areas of training were provided to staff on safe and correct use of equipment.
On October 26, 2012 resident #001 identified as a hydration risk was ordered by the physician to receive intravenous therapy 2/3 + 1/3 @75 cc hour for 3 days. Clinical record and staff interviews revealed that on October 27, 2012 , CCAC staff initiated the intravenous therapy. On October
29, 2012 the intravenous therapy was stopped and re-initiated on October 29, 2012 at 0945 hours by CCAC staff. On October 30, 2012 at 0600 hours the intravenous therapy was found to be stopped again and
reordered by the physician to continue for another 3 days due to the periodic stops and unknown quantity of hydration infused.
Direct care staff interviews revealed that training in the safe and correct use of IV therapy had not been provided in the home. An interview with the Staff Education Coordinator confirmed that training in the safe and correct use of IV therapy had not been provided in the home. [s. 218. 2.]

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 staff are trained in the safe and correct use of IV hydration equipment., to be implemented voluntarily.

Issued on this 27th day of November, 2012

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

Diane Brown