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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 21, 2017	2017_432654_0008	016740-16, 023812-16, 026406-16, 002859-17	Complaint

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

WESBURN MANOR
400 The West Mall ETOBICOKE ON M9C 5S1

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

SIMAR KAUR (654), NICOLE RANGER (189), NITAL SHETH (500)

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): April 26, 27, 28, 29, May 01, 02, 03, 04, 05, 08, 09, 10, 11, 12, 15, 16, 17, 18, 19, 23, 24, 25, and 26, 2017.

During the course of inspection following complaint inspections were conducted: Intake #002859-17-related to food quality, Intake #026406-16- related to food quality, cleanliness of dishware, nutrition, and laundry, Intake #023812-16-related to bathing, food quality and alleged abuse, and Intake #016740-16-related to provision of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Manager (NM), Registered Nursing Staff, and Personal Care Aides (PCAs), Dietary Aides, Cook, Nutrition Manager, Registered Dietitian (RD), Laundry Aide, Building Service Supervisor, Program Manager, and Recreational Assistant.

During the course of inspection, the inspector observed dining room services, kitchen area, laundry room services, staff to resident interactions, residents' care, reviewed residents health care records, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Dining Observation
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 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,
(f) communication to residents and staff of any menu substitutions; and 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,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

The licensee has failed to ensure that all menu substitutions were communicated to residents and staff.

Two complaints submitted to Ministry of Health and Long term-Care (MOHLTC), involved concerns related to food quality, temperature of food and cleanliness of dishware.

During dining observation of an identified meal service on an identified date, resident #035 and #036 were provided with an identified meal. Resident #035 and #036 could not identify the entree they had been served. Resident #035 asked Dietary Aide #120 about the entree and the staff could not identify entree he/she had served.

Record review of resident #035 and #36's weekly menu for the identified date indicated an identified meal item as an entree for the meal service.

Interview with the above mentioned residents revealed that they were served a different meal than indicated on the menu on the identified date. Both residents further stated that the menu substitution was not communicated to them prior to the meal service.

Interview with Dietary Aide #119 indicated that he/she did not receive any notification from the kitchen for menu substitution for above mentioned residents prior to the meal service on the identified date.

Interview with Nutrition Manager #122 revealed that as per the home's expectation all menu substitutions should be communicated to staff and residents prior to the meal service, and substitution was not communicated to resident #035 and #036 on the

identified date before the meal service.

The licensee has failed to ensure that all food and fluids were prepared, stored, and served using methods which prevent, contamination and food borne-illness.

Two complaints submitted to MOHLTH, involved concerns related to food quality, temperature of food and cleanliness of dishware.

During a dining observation of an identified meal service on an identified date, three hot meal plates and three cold meal plates were observed pre- poured and uncovered sitting on a cart while a Dietary Aide #120 had asked residents at a table for their choices. The Dietary Aide proceeded to the next table and served the pre- poured hot meal plates that had not been selected by the previous table.

Interview with Dietary Aide #120 indicated that he/she should have had only four plates on her cart as per the home's procedure. The staff further indicated that food should have been covered. An Interview with Dietary Aide #119 indicated that hot meal plates should be served directly from the steam table to maintain the required temperature.

Record review of the home's temperature record sheets on an identified date indicated no temperature record documentation for seven identified meal services in an identified month in 2017.

Interview with Dietary Aide #136 indicated that he/she had taken temperatures before three above mentioned identified meal services, and forgot to write on the record.

Interview with the Nutrition Manager #122 indicated that as per the home's Food Safety Program staff should not pre- pour hot meals and take on a cart prior to asking resident's choices to maintain temperature. He/she further revealed that hot food should be served directly from the steam table and should be covered to prevent food contamination and food borne- illness. The Nutrition Manager further acknowledged that during above mentioned identified meal service on the identified date, staff did not follow the home's food safety program as required.

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 are prepared, stored, and served using methods which prevent adulteration, contamination and food borne-illness, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

Two complaints submitted to MOHLTC, involved concerns related to food quality, temperature of food and cleanliness of dishware.

During a dining observation of an identified meal service on an identified date, inspector observed five pre- poured hot meal plates (with an identified three items) prepared for tray service from the beginning of the meal service at 1700 hours till 1745 hours. At the end of the meal service PCA #133 reheated the food in the microwave in above mentioned plates before taking to the residents' rooms. Interview with PCA #133 confirmed that he/she had prepared those meal plates at the beginning of the meal service as tray service for the residents' in their rooms, and left it until the dining meal service was over for around 45 minutes.

The PCA further indicated that he/she had pre- poured food in plates as he/she was concerned of running out of time at the end of meal service. The PCA further confirmed

that he/she should not had pre- poured hot meal on plates until a staff member was available to take those to the residents' rooms.

During an observation and interview with Nurse Manger #103, confirmed that he/she had taken one of the above mentioned pre -poured hot meal food plates, reheated in the microwave and provided it to resident #013 in his/her room on an identified date, after the meal service. The Nurse Manager had taken the temperature of two identified food items before serving and stated as follows: first identified item 125 degree F, and second identified item 121 degree F.

Interview with resident #013 indicated the food served to him/her on the above mentioned identified date, during the meal was cold. Nurse Manager #103 indicated in an interview that he/she had reheated the food in the microwave as the resident mentioned it was cold after being served.

Record review of the home's policy titled Plating meals in the dining room, # FN-0315-00, Published on January 10, 2016, indicated to ensure that food temperature a minimum of 60 degree C =140 degree F for hot food and a maximum of 5 degree C =40 degree F for cold food at each meal and are documented on the temperature record.

Interview with Nutrition Manager #122 revealed that as per the home's expectations dietary staff is required to take and record the food temperature before serving every meal. He/she further revealed that meal plates only should be prepared when staff is ready to serve the residents with tray service in order to maintain proper food temperature. Interview with Nurse Manager #103 and Nutrition Manager #122 stated that on the above identified date, at the meal service resident #013 was served above mentioned food items below required temperature as per the home's expectations.

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 food and fluids are served at temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #3: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A review of resident #048's written plan of care revealed that the resident exhibited identified responsive behaviors.

A review of the progress notes revealed that on an identified date, an identified documentation record was initiated after an incident when the resident had exhibited an identified responsive behaviour. The resident was seen by the doctor and doctor requested ongoing monitoring and detail observation in all shifts on the above mentioned documentation record.

A review of the resident's documentation record of monitoring revealed that it was initiated on the identified date, and there were several entries missing.

A review of the documentation record for an identified period of time revealed seven different identified dates the record was missing documentation.

A review of the home's policy #RC-0517-07, entitled, "Behavioural Response-Care Strategies: Modified Dementia Observation System", published March 1, 2015, indicated a procedure to complete the above mentioned identified documentation system as a component of the assessment for new and escalating behaviours in order to gain a better insight and understanding of the time, pattern, and antecedents leading to behavioral response when the root cause or triggers are difficult to identify.

Interview with PCA #167, RN #116, and Behavioural Support #156 revealed that the above mentioned missing documentation should have been completed by staff.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint submitted to MOHLTC, indicated that residents were not receiving baths as required.

The inspector randomly reviewed residents' health records, and found four identified residents who did not receive a bath twice a week as required. Record review revealed the following dates that the residents did not receive their scheduled bath:

-Resident #10 did not receive bath on nine different identified dates between the time periods of three identified months' in 2017.

-Resident #011 did not receive bath on ten different identified dates between the time periods of three identified months' in 2017.

-Resident #012 did not receive bath on three different identified dates between the time periods of two identified months' in 2017.

-Resident #022 did not receive bath on three different identified dates between the time periods of two identified months' in 2017.

Interview with PCA #149 and RPN #102 revealed that if a resident refuses to be bathed, the staff will re-approach the resident on another date and provide an alternative bath. PCA #149 reported that if the resident continues to refuse their bath, the staff will notify the registered staff that the resident had refused his/her bath. Further interview with RPN #102 revealed that if a resident refuses, the registered staff will document in the progress notes for the refusal. Record review with RPN #102 and DOC confirmed that there was no documentation of refusal of bathing for the identified residents on the above mentioned identified dates. Interview with RPN #102 and DOC confirmed that the identified residents did not receive their scheduled baths as required.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

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 :

The licensee has failed to ensure that the menu cycle included alternate choices of entrees, vegetables and desserts at lunch and dinner.

Two complaints submitted to MOHLTC, involved concerns related to food quality, temperature of food and cleanliness of dishware.

During dining observation of a identified meal service on an identified date, resident #035 was not provided with alternate choices for his/her entree by Dietary Aide #120.

Record review of resident #35's menu for an identified two days in different identified weeks, indicated an identified food item as main entrée and as the alternate choice on two different identified meal services.

Interview with Nutrition Manager #122 indicated that resident #035 had an identified menu, and all specific menus had been developed by a Registered Dietitian (RD) in collaboration with resident or their family. He/she further indicated that as per the home's expectation menu cycle should include alternate choices of entrees, vegetables and desserts at lunch and dinner.

Interview with Registered Dietitian (RD) #124 revealed that resident #035's menu cycle for above mentioned identified days did not include alternate choices of entrees.

The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

Two complaints were submitted to MOHLTC, involved concerns related to food quality,

temperature of food and cleanliness of dishware.

During dining observation of a identified meal service on an identified date, resident #035 and #036 were provided with an identified meal. Resident #035 and #036 could not identify main entree they had been served. Resident #035 asked Dietary Aide #120 about entree and the staff could not identify the entree he/she had served.

Record review of resident #035 and #36's menu for the identified date indicated an identified meal item in entree for the meal service.

Interview with the Dietary Aide #120, #119 and record review of resident # 35 and #36's plan of care revealed that resident #035 and #036 had an identified menu. Dietary Aide #119 further confirmed that resident #035 and #036 had been served a different meal item in the main entree during the meal service on above mentioned identified date, instead of the meal item stated on the menu.

Interview with the home's cook #121 confirmed that he/she had provided a different identified meal item for the above mentioned residents during the meal service as meal item listed on the menu was not available in the kitchen on the identified date.

Interview with resident #035 and #036 confirmed that they did not receive meal item as per the menu on the identified date.

Interview with the Nutrition Manager #122 indicated that as per home's expectations planned menu should be offered and available at each meal. He/she further revealed that resident #035 and #036 were not offered planned meal during the meal service on the identified date, as per the menu. He/she further indicated that their planned meal item was not available as the home did not receive from their food supplier.

Issued on this 5th day of July, 2017

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

Original report signed by the inspector.