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
Direction de l'amélioration de la performance et de la conformité

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

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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
Dec 31, 2013	2013_239503_0005	T-546-13	Complaint

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
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

LAURA BROWN-HUESKEN (503), STELLA NG (507)

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): December 9, 10, 11, 12, 13, 2013

During the course of the inspection, the inspector(s) spoke with Substitute Decision Maker, Residents' Council President, Family Council President, Registered Nursing Staff, Nutrition Managers, Nursing Manager, Registered Dietitian, Residents Services Manager, Director of Care and Acting Administrator.

During the course of the inspection, the inspector(s) reviewed clinical documentation, residents council minutes, family council minutes, and the home's policies related to unplanned weight changes and dietitian referrals.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration

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 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. The licensee failed to ensure that the home's Unplanned Weight Changes policy,

published 01/09/2013 was complied with.

The home's Unplanned Weight Changes policy, published 01/09/2013 states that the Registered Nurse, Registered Practical Nurse and Nutrition Manager are to refer to the Dietitian for any significant unplanned increases or decreases in weights. The policy states that the Dietitian is to complete an assessment and develop strategies as appropriate. Significant unplanned weight changes are defined as 5% of body weight over a one month period, 7.5% of body weight over a three month period, and 10% of body weight over a six month period.

A review of the Weight Monitoring Record for resident #001 shows that the resident experienced a significant weight gain of greater than 5% over a one month period. Nursing documentation indicates that a Dietitian Referral Form was sent related to this weight change. An assessment by a Dietitian was not completed at this time. Interview with Nutrition Manager confirmed that a Dietitian assessment should have been completed for this significant weight change. [s. 8. (1)]

2. A review of the quarterly nutrition assessment form, Q3M Nutrition Review completed by an identified Nutrition Manager, for resident #003 indicates a weight gain of greater than 7.5% over a three month period. There was no referral sent to the Dietitian. Interview with Nutrition Manager confirms that this weight gain should have been referred to the Registered Dietitian for assessment. [s. 8. (1)]

3. The home's Unplanned Weight Changes policy, published 01-09-2013, states that residents are to be weighed once monthly and, when there is a 2kg change in weight, the resident is to be reweighed. Review of the Weight Monitoring Record for resident #002 shows a weight loss of greater than 2kg over a one month period. Interview with Nutrition Manager confirmed there was no reweigh conducted to confirm this weight loss and that there was no referral to the Dietitian for assessment of this weight loss. [s. 8. (1)]

4. Review of the Weight Monitoring Record for resident #004 shows a weight loss of greater than 10% in a six month period. No referral to RD was made for assessment of this weight loss. Review of the weight monitoring record for resident #004 shows a weight gain of greater than 2kg in a one month period, there was no reweigh conducted to confirm weight gain. Interview with the Nutrition Manager confirms that a referral should have been sent to the Dietitian for the significant weight loss and that a reweigh should have been taken related to the weight change of greater than 2kg in

one month. [s. 8. (1)]

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 the home's Unplanned Weight Changes policy, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 26 (4).
(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. The licensee failed to ensure that a registered dietitian, who is a member of the staff of the home, complete a nutritional assessment whenever there is a significant change in a resident's health condition.

A review of weight monitoring record for resident #001 shows that the resident had a significant weight gain of greater than 5% over a one month period. Review of the progress notes for resident #001 reveal that the resident received a new order for a diuretic medication and two subsequent dosage increases in an identified period of time. Resident #001 also received a new medical diagnosis in this time period. The home's Registered Dietitian did not assess resident #001 for two months following the identified time period. An interview with the Director of Care confirmed that resident #001 experienced a significant change in health condition in the identified time period, and that the home's Registered Dietitian should have been notified of the change and assessed the resident at that time. [s. 26. (4)]

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 for ensuring that a registered dietitian, who is a member of the staff of the home, complete a nutritional assessment whenever there is a significant change in a resident's health condition, to be implemented voluntarily.

WN #3: 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. The licensee failed to ensure that residents with significant weight changes are assessed using and interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Review of the weight monitoring record for resident #002 shows that the resident had a weight loss of greater than 5% of body weight in a one month period. Review of clinical records found no assessment of this significant weight change. Interviews with Registered Nursing staff and Nutrition Manager confirmed that there was no assessment of this significant weight change. [s. 69.]

2. Resident #003 had a weight gain of greater than 5% of body weight in a one month period. The reweigh conducted to confirm this weight gain, indicated a weight loss of greater than 5% of body weight. The following month's weight for resident #003 was above the identified usual/ideal weight. The Q3M Nutrition Review indicates a weight gain of greater than 7.5% over the previous 3 months and confirms the weight was above the usual/ ideal weight. Review of clinical documentation and interviews with Registered Nursing Staff and Nutrition Manager confirm that there were no assessments of this significant weight gain. [s. 69.]

3. Review of the weight monitoring record for resident #004 shows that the resident had a weight loss of greater than 10% of body weight in a six month period. Review of clinical records found no assessment of this significant weight change. Interviews with Registered Nursing staff and Nutrition Manager confirmed that there was no assessment of this significant weight change. [s. 69.]

4. Review of weight monitoring record for resident #001 shows a significant weight gain of greater than 5% in a one month period. In progress notes, registered nursing staff indicate leg edema and refer to the physician for assessment. The physician ordered a diuretic medication. Nursing documentation indicates that a Dietitian referral form has been sent due to increase in weight. Interview with Director of Care indicated that and interdisciplinary approach to assessing significant weight changes includes assessment by nursing staff as well as referrals to physician and dietitian for assessment. No dietitian assessment was completed related to this significant weight gain. [s. 69.]

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

WN #4: 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care is reviewed and revised if the care set out in the plan has not been effective.

Review of the written plans of care for resident #003 stated the goal of maintaining an identified weight, with no changes to nutrition interventions during the care plan update. The Q3M Nutrition Review, of an identified date, completed by a Nutrition Manager indicates an Usual/Ideal weight range, and a current weight above that range with significant weight gain of greater than 7.5% noted over three months. Despite this undesired weight gain, the Q3M Nutrition Review states no changes in interventions and the plan of care was was not revised. [s. 6. (11) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that copies of the inspection reports from the past two years for the long-term care home are posted in the home.

On December 10, 2013 the inspector observed the following inspection reports were not posted in the home:
2013_102116_0001 from January 28, 2013
2012_102116_0045 from January 23, 2013
2012_07649_0005 from April 4, 2012
2012_07649_0003 from April 4, 2012
2012_07649_0007 from April 4, 2012
The absence of the reports was confirmed in an interview with the administrator. [s. 79. (3) (k)]

Issued on this 6th day of January, 2014

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

L. Brown-Hueston