



**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**

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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
May 17, 2013	2013_157210_0011	T-67-13, T155-13, T- 72-13	Complaint

Licensee/Titulaire de permis

Downsview Long Term Care Centre Limited
3595 Keele Street, NORTH YORK, ON, M3J-1M7

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

Downsview Long Term Care Centre
3595 Keele Street, NORTH YORK, ON, M3J-1M7

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

SLAVICA VUCKO (210)

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): May 6, 7, 8, 9, 10, 13, 2013

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Practical Nurses, Registered Nurses, Registered Dietitian

During the course of the inspection, the inspector(s) Reviewed the clinical records, Flow Sheets, Intake and Output records

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

Personal Support Services

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



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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. 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 the Registered Dietitian (RD) who is a member of the staff of the home completed a nutritional assessment for the resident when there was a significant change in the residents' health condition, including the residents' nutritional status, weight and any risks related to nutrition care, hydration status, and any risks related to hydration.

In November 2012 Resident #1 had a significant change in her health status and decreased daily oral intake for five days. In order to meet the daily fluid requirements, the nutritional care plan for Resident #1 indicated that 1400-1500cc fluids was required daily. Staff interview and review of documentation indicated that the Registered Dietitian was not aware of the decreased intake, significant change in the resident's health condition and consequently did not complete a nutritional assessment for the resident.

A newly admitted Resident #2 had a significant change in his/her health condition. The admission nutrition assessment indicated that the resident previously had poor eating habits and an average fluid intake of 1000-1500cc/day. During the first week of admission, the Nutrition and Hydration Flow sheet indicated decreased daily fluid intake than the average, for seven days. Resident was sent to hospital for decreased level of consciousness and possible dehydration. The RD who is a member of the staff of the home, was not aware of the significant change in resident's health condition and did not complete a nutritional assessment for the resident. The RD did not assess the resident's hydration status, and any risks related to hydration. [s. 26. (4)]

WN #2: 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.



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Findings/Faits saillants :

1. The licensee failed to ensure that Resident #1 with the following weight changes was assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

Resident #1 was admitted to the home in July 2012. The weight was taken each month and varied from the resident's ideal body weight. The weight was as follows: July 2012 57.3kg, August 62.1kg, September 56.7kg, October 56.4 kg and November 52.1 kg. In July 2012, during the initial assessment, resident was assessed by the RD and Registered Staff to be at high nutritional and hydration risk because of her medical condition. In October 2012, the quarterly assessment was the same as the initial one plus the resident was leaving more than 25% food at meals. On September 04, 2012 resident had a weight change, loss of 8.7% compared to the weight of August 07, 2012. Staff interview and clinical record review indicated that no action was taken related to the weight change of 8.7% of body weight over one month. There was no interdisciplinary assessment completed and outcomes evaluated. [s. 69.]

Issued on this 17th day of May, 2013

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

A handwritten signature in blue ink, appearing to be "B. H. H.", written within a rectangular box.