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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 14, 2015	2015_382596_0003	T-1769-15	Resident Quality Inspection

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

THERESA BERDOE-YOUNG (596), JANET GROUX (606), NICOLE RANGER (189), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 2015.

During the course of the inspection the following critical incident,complaint and follow up inspections were completed:T-638-13, T-511-14, T-1151-14, T-1163-14, T-1617-15, T-1351-14, and T-836-14.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of care (A)DOC, nurse managers, social worker (SW), registered dietitian (RD), behavioural support ontario (BSO), volunteer coordinator, resident assessment instrument (RAI) coordinator, registered nurse (RN), registered practical nurse (RPN), rehab assistant, skin care coordinator, personal care assistants (PCA), housekeeper, residents' council president, family council president, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

12 WN(s)
5 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #001	2014_312503_0018	596

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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is complied with.

The home's policy entitled Narcotic and Controlled Substances PH-0106-00, published January 6, 2012, indicated that two nurses, one from the outgoing shift and one from the oncoming shift, will count narcotics and controlled substances utilizing Narcotic and Controlled Substances Record. The policy directs staff to record the declining balance on the narcotic record and maintain this record in front of the medication administration record (MAR) for the individual resident.

On March 23, 2015, the inspectors observed the following for the off hours narcotic record:

1. Inspector 604 reviewed the Narcotic off hours record for an identified unit at 9:05 a.m. and observed that the 3:00 p.m. shift count for March 23, 2015 was already pre signed for eight medications.
2. Inspector 189 reviewed the Narcotic off hours record for an identified unit at 11:30 a.m. and confirmed the pre-signing of shift count.
3. Inspector 189 interviewed the identified registered staff on the identified unit mentioned above who confirmed that he/she did pre-sign the narcotics shift count for 3:00 p.m. and he/she did not complete the count with a second registered staff present.
4. Inspector 189 interviewed the nurse manager and (A) DOC and confirmed that the identified registered staff did not follow the narcotic and controlled substances policy.

On March 23, 2015, the inspector observed the following for standing narcotic record:

5. Inspector 189 reviewed the standing Narcotic Medication record on all units in the home and observed a total of 12 entries where one registered staff member completed the narcotic shift count independently without a second registered staff member present.
6. Inspector 189 interviewed the (A) DOC and confirmed for the 12 entries that one registered staff member completed the narcotic shift count independently, these staff members did not follow the narcotic and controlled substances policy.

Non-compliance to s.8 (1) of the Long Term Care Homes Act (LTCHA) was previously identified in inspection 2014_312503_0018 on October 3, 2014, with an order issued. The order issued on October 3, 2014, was to ensure that the home's Narcotic and

Controlled Substance policy and the home's Off hours Medication Supply policy is complied with. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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).

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 licensee has failed to ensure that staff and others who provide direct care to a resident is kept aware of the contents of the plan of care and have convenient and immediate access to it.

Record review of an identified resident's care plan dated October 23, 2014, with an identified PCA identified resident as high risk for falls.
On March 19, 2015, interview with an identified personal care assistant (PCA) on an identified unit revealed that he/she was unaware that the resident was identified as high

risk for falls and had not reviewed the identified resident's care plan for more than two months.
An interview with the (A)DOC confirmed that staff are expected to review resident's care plans to ensure staff are knowledgeable of each residents safety risk and interventions. [s. 6. (8)]

2. The licensee shall ensure the provision of care set out in the plan of care is documented.

Review of an identified resident's quarterly nutritional review dated January 9, 2015, indicated that the resident was at moderate nutritional risk. Review of the home's policies entitled Guidelines for Dining Room Service #RC-0523-02 last reviewed on January 7, 2013, and Snacks and Supplements Service #RC-0523-15 last reviewed on January 6, 2010, direct staff to ensure that each resident is monitored, assistance is provided, and food and fluid intake is documented on the Nursing and Personal Care Record (NPCR).

Record Review of the identified resident's NPCR for food and fluid intake revealed missing documentation for breakfast, lunch, dinner, and snack times between December 2014 to March 13, 2015. There were a total of 123 entries where the resident's meal and snack consumption was not documented.

Interview with identified nursing staff confirmed they are responsible to document the identified resident's food and fluid intake in the NPCR, and had not done so. Interview with the (A) DOC confirmed that it is the expectation of the home that staff document resident's food and fluid intake in the NPCR, and confirmed that staff failed to document. [s. 6. (9)]

3. Record review of an identified resident's progress notes revealed that the resident developed an open area on the right buttock in October 2014. An intervention in the resident's care plan on an identified date in February 2015 directs staff to change the resident's position every two hours in bed and in chair by using a transfer sheet to prevent shearing of the skin, then
document on the home's Resident Turning/Positioning Schedule Worksheet.

Record review of the identified resident's Turning/Positioning Schedule Worksheet revealed that staff did not document for the months of October 2014, December 2014, and January 2015. There was also a total of 184 missing entries between February and March 2015.

Interview with an identified RPN revealed that the resident is to be repositioned every two hours according to his/her care plan, with documentation on the Resident Turning/Positioning Schedule Worksheet. Interview with the (A)DOC confirmed that the home’s expectation is for staff to reposition residents according to their care plan and document, and they were not doing it for the time frames mentioned above. [s. 6. (9)]

4. The licensee has failed to ensure that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Record review of two identified resident's plan of care revealed that there were no reassessments completed for both residents' bladder and bowel management beyond the admission assessments dated February 6, 2013 for one resident, and December 6, 2011 for the other resident.

Interview with an identified nurse manager revealed that staff did not complete bladder and bowel management reassessments for the two residents, and the home is in the process of educating staff to document on a continence assessment tool. [s. 6. (10) (b)]

5. Record review revealed that an identified resident had a change in condition on September 2014, and was assessed by the physician and diagnosed with a medical condition. The resident's care plan was not updated to reflect this change in condition.

Interview with an identified registered staff confirmed that the resident had been diagnosed with a medical condition in September 2014 and the care plan was not updated. Interview with the (A)DOC revealed that it is the expectation of the home that staff review and revise residents’ care plans whenever there is a change in a resident's condition, and confirmed that the identified resident's care plan should have been reviewed, revised and updated. [s. 6. (10) (b)]

6. Plan of care for an identified resident in October 2014, directs the staff to implement specific interventions when co-resident may be in bed during the day hours for an identified room, and call bell awareness and monitoring are extremely important for the staff to be aware of. Plan of care also directs the staff to place cereal on a table in a monitored environment or to engage the resident in a specific activity as this will decrease the wandering and behaviours.

On an identified date in March 2015, the inspector heard a loud scream coming from the hallway on an identified unit. Upon approaching an identified room, the inspector observed an identified resident walking in the hallway with the specific interventions wrapped in his/her hands. Inspector observed another identified resident in the same room visibly shaken in a wheelchair with a pool of water on the floor. The second identified resident reported to the inspector that the first identified resident came into his/her room and threw a glass of water at him/her, as the resident has come into the room before and he/she is scared of the resident. Inspector observed that there was not staff present for monitoring as this incident occurred during shift report.

On another identified date in March 2015, inspector 604 observed an identified resident in an identified resident's room, flipping over the mattress with the resident in the room. Inspector reported that the resident was wandering in the hallways and no staff were present monitoring the resident.
Interview with an identified staff revealed that the resident is resistive in the evenings, and will often wander into co-residents rooms, and turn the furniture and mattress upside down. The identified staff reported that they try to monitor the resident, but they are also busy with other residents on the unit. Interview with the (A)DOC and the Behaviour Supports Ontario (BSO) staff reported that the current plan of engaging the resident in a specific activity was implemented, but not effective. Interview with the BSO staff revealed that new approaches to monitor the resident care have been discussed but not implemented as of the present time. [s. 6. (10) (b)]

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 and others who provide direct care to a resident is kept aware of the contents of the plan of care and have convenient and immediate access to it, and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication response system can be easily seen, accessed, and used by residents.

On March 18, 2015, the inspector observed and identified resident's call bell was inaccessible to the resident who was in bed. The call bell was wrapped around the left bed rail three times, and the bed rail was in the up position. Interview with the resident confirmed that he/she was unable to reach the call bell. Interview with an identified PCA confirmed that the call bell was inaccessible, to the resident and the call bell was immediately placed in the resident's right hand. [s. 17. (1) (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 that the resident-staff communication response system can be easily seen, accessed, and used by residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Findings/Faits saillants :

1. The licensee failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected.

Record review and staff interview revealed that on an identified date in September 2014, an identified PCA reported that the call bell was ringing in an identified room and when the PCA approached the room, the door was closed. The PCA opened the door to discover an identified resident in another identified resident's room close to the window, with a remote in his/her hands. The second identified resident was lying in bed with the call bell positioned in an unsafe manner. The PCA reported that the room was dishevelled. The PCA revealed that he/she repositioned the call bell and then proceeded to remove the first identified resident out of the room. The PCA reported this incident to the registered staff. The first identified resident was placed on 1:1 monitoring during an identified shift.

On another identified date in September 2014, an identified registered staff reported that during the night shift, the first identified resident was found wandering in his/her room and attempted to push his/her roommate out of bed. Identified staff reported that the first identified resident was restless and wandering on the unit.

On another identified date in September 2014, on an identified shift, an identified registered staff reported that the first identified resident was found wandering in his/her room, and the roommate, was found lying in the bed with his/her face covered with an incontinent brief, and the call bell positioned in an unsafe manner. The identified RPN reported that he/she repositioned the call bell cord, and then proceeded to take the other resident out of the room where he/she was left to wander on the unit. Later that day an identified PCA reported that he/she was informed by the night PCA that they could not locate the first identified resident. The identified PCA carried out a search and discovered the identified resident in an identified room where another identified resident was sleeping. The first identified resident was discovered placing shoes on the other identified resident's feet, then proceeded to place his/her hands over the resident's face while he/she was protesting. The first identified resident was removed from the room, and the

registered nurse contacted the nurse manager. The nurse manager contacted the police and arrangements were made for this resident to be sent to hospital for assessment.

Interviews with three identified staff revealed that for six days in September 2014, there was no 1:1 monitoring for the first identified resident during the day or night shifts. Identified staff reported that it is during the evening and night hours that the first identified will exhibit behaviours. The staff confirmed that this resident has responsive behaviours towards the staff and other co residents.
Interview with the (A)DOC confirmed that 1:1 staffing was only assigned on the evening shift during the above mentioned six days in September 2014.
The inspector also noted during record review and staff interview that on January 26, 2014, the first identified resident was found in an identified resident's room, and the identified resident was found lying in bed with the call bell wrapped around their neck. The resident was also observed on that day to be going in and out of residents’ room and unplugging the call bells. [s. 19.]

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 are protected from abuse by anyone and shall ensure that residents are not neglected, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 65. No interference by licensee
A licensee of a long-term care home,
(a) shall not interfere with the meetings or operation of the Residents' Council or the Family Council;
(b) shall not prevent a member of the Residents' Council or Family Council from entering the long-term care home to attend a meeting of the Council or to perform any functions as a member of the Council and shall not otherwise hinder, obstruct or interfere with such a member carrying out those functions;
(c) shall not prevent a Residents' Council assistant or a Family Council assistant from entering the long-term care home to carry out his or her duties or otherwise hinder, obstruct or interfere with such an assistant carrying out those duties; and
(d) shall ensure that no staff member, including the Administrator or other person involved in the management or operation of the home, does anything that the licensee is forbidden to do under clauses (a) to (c). 2007, c. 8, s. 65.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home shall not interfere with the meetings or operation of the Family Council.

Interview with the Family Council chair revealed that a memo notifying family members of monthly Family Council meetings was placed throughout the home. The Family Council chair reported that between January and February 2015 he/she observed that the memos on the 3rd and 4th floors were removed. The Family Council chair reported that the memo was a standing memo with no expiry dates, inviting family members to attend Family Council meetings held on the second Tuesday of the month (September to November 2014 and January to June 2015).
Interview with the administrator and identified staff members confirmed that a Family Council memo was removed from the main, 3rd and 4th floor walls between January and February 2015, as the date of the Family Council meeting had passed. [s. 65.]

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 the home shall not interfere with the meetings or operation of the Family Council, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that that all direct care staff receive the required training annually in responsive behaviours and behaviour management as per s.76 (7) of the LTCHA 2007.
Record review of the home's 2014 training records and interview with the (A) DOC confirmed that 45 per cent of staff did not receive training on responsive behaviours, and 70 per cent of staff did not receive training on behavioural mangement. [s. 221. (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 that all direct care staff receive the required training annually in responsive behaviours and behaviour management as per s.76 (7) of the LTCHA 2007, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Interview with an identified resident revealed that on an identified date in March 2015, an identified PCA on the evening shift responded to his/her call bell and was speaking loudly making negative remarks about having to answer the call bell. Interview with the identified resident's roommate confirmed the incident. The identified resident reported that the manner in which the staff member handled the incident did not show him/her courtesy and respect. [s. 3. (1) 1.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, that the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The home's policy entitled Falls Prevention and Management #RC-0518-21 indicates that all residents who have fallen require an interdisciplinary team assessment to clearly understand the contributing factors and appropriate interventions to prevent future falls. A "Post Fall Assessment Huddle" shall be completed after each fall prior to the end of the shift. Best practice information states that a fall risk assessment and the Morse Fall Scale are conducted by the interdisciplinary team for all residents who sustain a fall or who continue to fall.
Record review of an identified resident's plan of care revealed that the resident sustained nine falls from September 2013 to June 2014. The following assessments were not completed after each fall on the identified dates below:
-September 20, 2013 - Morse falls assessment and post fall assessment huddle
-January 27, 2014 - Morse falls assessment and post fall assessment huddle
-February 5, 2014 - Morse falls assessment and post fall assessment huddle
-April 29, 2015 - Morse falls assessment.
Interview with the (A) DOC confirmed there were missing Morse fall assessments and post fall assessment huddles for the resident falls identified above. [s. 49. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Record review of a letter of concern dated February 26, 2015, submitted to the administrator by the Family Council chair, and interviews with the administrator and family member confirmed that a response was not sent back to the family member within 10 days of receiving the letter of concern. The administrator confirmed during interview on March 16, 2015, that he/she did not remember to respond and would send a response to the family member immediately. [s. 60. (2)]

WN #10: 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.

Observation on March 9, 2015, during the initial tour and record review on March 10, 2015, revealed that the following inspection report was not posted in the home:
Inspection # 2013-158101-0038
The above observation was confirmed by the administrator. [s. 79. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On an identified date in March 2015, at 09:10 a.m. the inspector was conducting an interview with an identified resident and observed a white paper medication cup with the resident's name marked in red, on his/her over bed table. The inspector observed that there were eight tablets inside the medication cup. During the course of the interview which concluded at 10:20 a.m. no registered staff had come to the room to observe if the medication was taken. Record review of an identified resident's medication administration record (MAR) revealed that morning medications were signed off as administered for the identified date in March 2015.

At 10:25 a.m., the inspector and an identified RPN observed the eight tablets still in the medication cup in the resident's room. The identified RPN confirmed that there were eight tablets in the medication cup and the identified resident's MAR was pre-signed.

The home's policy entitled Medication Administration #PH-0205-00 directs staff to remain with the resident until medication is swallowed. The home's policy entitled Medication Administration-General Rules #PH-0202-00 direct staff to record administration of medication immediately after administering and to verify resident has swallowed the medication. Interview with the (A)DOC confirmed that no medication is to be left at the bed side unattended unless there is an order for self-medication. [s. 131. (5)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that the infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's policy entitled Tuberculosis Screening, Section Three-Surveillance, reviewed on March 1, 2015, indicates that the physician will order a two-step Mantoux test including dosage and route for every resident upon admission unless the resident has been
screened 90 days prior to admission and the documented results of this screening are available, and is not in accordance with evidenced-based practice.

Review of the Toronto Public Health Tuberculosis (TB) screening recommendations in Long Term Care Facilities dated April 18, 2013, recommends that TB screen for all new residents be based on a history and physical examination by a physician/nurse practitioner within 90 days prior to admission or within 14 days after admission. It is recommended that this assessment include the following:
A symptom review for active pulmonary TB disease.

A chest x-ray (posterior-anterior and lateral) taken within 90 days prior to admission to the facility. If signs and symptoms and/or chest x-ray indicate potential active pulmonary TB disease, the resident should not be admitted until three sputum samples taken at least eight hours apart are submitted to the Public Health Lab for testing (Acid Fast Bacilli and Culture) and the results are negative.
In addition to the above, for residents less than 65 years of age who are previously skin test negative, or unknown, a 2-step tuberculin skin test (TST) is recommended. If the TST is positive, treatment of latent TB infection (LTBI) should be considered. A TST is not recommended for residents with a previous positive TST.
Tuberculin skin tests are not recommended to be done routinely upon admission for residents 65 years of age or older. If a TST was previously done, record the date and result of the most recent TST.

Record review of the home's Infection Control Manual-Toronto Long-Term Care Homes and Services-Policy IC-0303-00 dated May 1, 2009, next review date May 1, 2009-Section-Surveillance-Policy-Tuberculosis Screening indicates that all residents shall have a 2-step tuberculin skin test (TST) within 14 days of admission, regardless of prior BCG vaccination, unless documented results of a previous 2-step TST done within the last 6 months are available.

Interview with the (A)DOC confirmed that the home follows their policy IC-0303-00 as outlined above does not screen new residents for TB as per the evidence based Toronto Public Health guidelines. [s. 229. (2) (d)]

2. The licensee has failed to designate a staff member to co-ordinate the infection prevention and control program who has education and experience in infection prevention and control practices, including, (a) infectious diseases; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management.

Record review of the home's infection control lead's training and educational experience revealed that the infection control lead has not received the education and training in infection prevention and control practices including infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.
Interview with the infection control lead confirmed that he/she has not received the required education and training. [s. 229. (3)]

3. The licensee has failed to ensure that all staff participate in the implementation of the program.

On March 9, 2015, in an identified spa room the inspector observed used and unlabelled personal care items: two hairbrushes and a bar of white soap in its original container. Interviews with identified nursing staff revealed that the items belonged to a resident and the home’s practice is residents’ personal care items are labeled with the resident’s name and kept in their rooms.
Interview with the (A)DOC revealed that the home's practice is that residents' personal care items should be labeled with the resident's name and kept in their room, and confirmed that the above mentioned personal care items should have been labeled with the resident’s name and kept in their rooms. [s. 229. (4)]

Issued on this 27th day of May, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	THERESA BERDOE-YOUNG (596), JANET GROUX (606), NICOLE RANGER (189), SHIHANA RUMZI (604)
Inspection No. / No de l'inspection :	2015_382596_0003
Log No. / Registre no:	T-1769-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 14, 2015
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	WESBURN MANOR 400 The West Mall, ETOBICOKE, ON, M9C-5S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Judy Watson

To TORONTO LONG-TERM CARE HOMES AND SERVICES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_312503_0018, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan outlining how the home will ensure the following policy is complied with: The home's Narcotic and Controlled Substances policy.
The licensee shall prepare, submit and implement a plan that shall include, but not limited to the following:
1. Develop and implement a system to monitor and evaluate the adherance to the policy.
2. Ensuring that two registered staff, one from the outgoing shift and one from the oncoming shift, will count narcotics and controlled substances at all times.
3. Re-educate all registered staff on the policy and procedure for Narcotic and Controlled Substances.

The plan should identify who will be responsible for completing all of the identified tasks and when these tasks will be completed

Please submit plan to Nicole.Ranger@ontario.ca by May 29, 2015

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is complied with.

Non-compliance to s.8 (1) of the Long Term Care Homes Act (LTCHA) was previously
identified in inspection 2014_312503_0018 on October 3, 2014 with an order issued.
The order issued on October 3, 2014 was to ensure that the home's Narcotic and Controlled Substance policy and the home's Off hours Medication Supply policy is complied with.

The home's policy entitled Narcotic and Controlled Substances PH-0106-00, published January 6, 2012, indicated that two nurses, one from the outgoing shift and one from the oncoming shift, will count narcotics and controlled substances utilizing Narcotic and Controlled Substances Record. The policy directs staff to record the declining balance on the narcotic record and maintain this record in front of the medication administration record (MAR) for the individual resident.

On March 23, 2015, the inspectors observed the following for the off hours narcotic record:

1. Inspector 604 reviewed the Narcotic off hours record for an identified unit at 9:05 a.m. and observed that the 3:00 p.m. shift count for March 23, 2015 was already pre signed for eight medications.
2. Inspector 189 reviewed the Narcotic off hours record for the above mentioned identified unit at 11:30 a.m. and confirmed the pre-signing of shift count.
3. Inspector 189 interviewed the identified registered staff on the unit who confirmed that he/she did pre-sign the narcotics shift count for 3:00 p.m. and he/she did not complete the count with a second registered staff present.
4. Inspector 189 interviewed the nurse manager and (A) DOC and confirmed that the identified registered staff did not follow the narcotic and controlled substances policy.

On March 23, 2015, the inspector observed the following for standing narcotic record:

5. Inspector 189 reviewed the standing Narcotic Medication record on all units in the home and observed a total of 12 entries where one registered staff member completed the narcotic shift count independently without a second registered

staff member present.
6. Inspector 189 interviewed the (A) DOC and confirmed for the 12 entries that one registered staff member completed the narcotic shift count independently, these staff members did not follow the narcotic and controlled substances policy.

(189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 12, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 14th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Theresa Berdoe-Young

Service Area Office /
Bureau régional de services : Toronto Service Area Office