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

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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
Jun 2, 2017	2017_486653_0009	034861-16	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

ROMELA VILLASPIR (653)

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): May 4, 5, 8, and 9, 2017.

During the course of the inspection, the inspector conducted resident observations, and reviewed the resident's health records, staff schedules, staff training records, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with resident #001's Substitute Decision-Maker (SDM), Personal Care Aides (PCAs), Registered Practical Nurses (RPNs), Registered Nurse (RN), and the Director of Care (DOC).

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint on an identified date, related to the home's skin and wound care program.

Review of resident #001's progress note on an identified date, indicated that an identified individual asked to see the Registered Nurse (RN), as the identified individual noted two areas of altered skin integrity on an identified body part of resident #001.

Interview with the identified individual stated that on an identified date, resident #001 may have injured an identified area of the body. The identified individual further stated that when he/she checked the the identified body part, he/she had seen an identified number of areas of altered skin integrity. The individual reported to the registered staff.

Record review of resident #001's written plan of care last updated on an identified date, identified him/her as being at a high risk for obtaining altered skin integrity.

Record review of progress notes revealed that the area of altered skin integrity had healed on an identified date. Review of resident #001's written plan of care last updated on an identified date, directed registered staff to complete a weekly skin assessment and assess his/her pain every shift.

Interview with RN #100 stated that the home's practice when conducting weekly altered skin integrity assessment was to document the assessment on the progress notes, weekly ulcer/ wound assessment record sheets, and sign off on the Treatment Administration Record (TAR) after conducting the assessment.

Review of resident #001's TAR on an identified date, revealed that the weekly skin/ wound assessment had been signed off as completed by the registered staff on two identified dates. Review of resident #001's health records did not identify the corresponding weekly ulcer/ wound assessment record sheets for the weekly skin/ wound assessments completed on the two identified dates. Review of progress notes did not indicate that the resident's skin had been assessed by registered staff on the two identified dates. Review of progress notes did not identify that his/her pain had been assessed each shift by the registered staff following the identified date.

During an interview, RN #100 confirmed that resident #001's skin had not been assessed weekly on the two identified dates, and that the resident's pain had not been assessed each shift following the identified date. The RN acknowledged that the care set out in the plan of care had not been provided to the resident as specified in the plan.

During an interview, the Director of Care (DOC) acknowledged that the care set out in resident #001's plan of care had not been provided to the resident as specified in the plan. [s. 6. (7)]

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

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint on an identified date, related to the home's skin and wound care program.

Review of resident #001's progress note on an identified date, indicated that an identified individual asked to see the Registered Nurse (RN), as the identified individual noted two areas of altered skin integrity on an identified body part of resident #001.

Interview with the identified individual stated that on an identified date, resident #001 may have injured an identified area of the body. The identified individual further stated that when he/she checked the the identified body part, he/she had seen an identified number of areas of altered skin integrity. The individual reported to the registered staff.

Review of resident #001's written plan of care last updated on an identified date, indicated he/she was at high risk for/ or has an identified skin impairment as evidenced by an identified ailment related to identified co-morbidities. The written plan of care directed Personal Care Aides (PCAs) to inspect the resident's skin and to report any identified areas of altered skin integrity to the RN/ Registered Practical Nurse (RPN).

Review of resident #001's Nursing and Personal Care Record (NPCR) on an identified date, for the night shift, and on an identified date, for the day shift, did not indicate any documentation by the PCAs on the following entries under section G. Activities of Daily Living (ADL): Skin observed and intact, skin observed and not intact (report to RN/RPN), and skin could not be observed (report to RN/RPN).

Interviews with PCAs #101, #102, and #103, stated that it was the PCA's responsibility to

document on the NPCR if he/she had observed or could not observe the resident's skin during each shift.

Interview with RN #100 stated that it was the home's expectation that all staff document the care provided to the resident as set out in the plan of care.

During an interview, the DOC acknowledged the lack of documentation from the PCAs, and that the PCAs did not document the care provided to resident #001 as set out in the plan of care. [s. 6. (9) 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 ensure that the care set out in the plan of care is provided to the resident as specified in the plan and that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: 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. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided training in skin and wound care.

A review of the home's training records for skin and wound care revealed the following:
-In 2015, 17 out of 85 PCAs, and 9 out of 56 registered staff were not trained.
-In 2016, 11 out of 80 PCAs, and 10 out of 63 registered staff were not trained.

Interview with the Supervisor for Administrative Services confirmed that the home did not have 100 per cent completion for the PCAs and registered staff's skin and wound care training in 2015 and 2016. [s. 221. (1) 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 training in skin and wound care is provided to all staff who provide direct care to residents, to be implemented voluntarily.

WN #3: 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 has failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted in the home.

The MOHLTC received a complaint on an identified date, related to the home's skin and wound care program.

During an interview, the complainant indicated to the inspector that the home had not been posting the MOHLTC public inspection reports on their bulletin board.

During an observation on May 4, and 5, 2017, it was noted that inspection #2016_265526_0008 report date: April 25, 2016, had been the only inspection report posted on the Ministry of Health information bulletin board located on the ground floor. The following inspections were not posted:
-#2015_393606_0010 report date: November 20, 2015,
-#2015_297558_0014 report date: August 19, 2015,
-#2015_297558_0011 report date: August 10, 2015,
-#2015_382596_0003 report date: May 14, 2015.

During an interview, the DOC confirmed that the above-mentioned MOHLTC public inspection reports of the home within the last two years were not posted in the home as required. [s. 79. (3) (k)]

Issued on this 14th day of June, 2017

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

Original report signed by the inspector.