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 23, 2017	2017_659189_0009	009314-16, 013811-16, 017232-16, 023204-16, 023931-16, 024500-16, 026738-16, 027337-16, 029005-16, 033266-16, 033413-16, 034441-16, 000554-17, 006076-17	Critical Incident System

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

NICOLE RANGER (189), ROMELA VILLASPIR (653), SARAN DANIEL-DODD (116), SIMAR KAUR (654)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 24, 25, 26, 27, 28, May 1, 2, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 23, 24, 25, 26, 2017

The following intakes were inspected concurrently during this inspection Critical Incident (CI) intakes related to medication: #023204-16, 033266-16, 000554-17, intakes related to abuse: 009314-16, 013811-16, 017232-16, 024500-16, 029005-16, 006076-17, intakes related to responsive behaviours: 023931-16, 027337-16, 033413-16, intakes related to transferring and positioning: 026738-16, intakes related to falls prevention: 024441- 16.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Nurse Manager, Physiotherapist (PT), Occupational Therapist (OT), Food Service Manager (FSM), Food Service Worker, Building Service Supervisor, Registered Dietitian (RD), RAI Coordinator, registered staff, personal care workers (PCA), residents and family members.

During the course of the inspection, the inspector conducted a tour of the resident home areas, observed resident and staff interactions, reviewed clinical health records and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there was a written plan of care for each resident that set out the planned care for the resident; the goals the care was intended to achieve; and clear directions to staff and others who provided direct care to the resident.

On an identified date, at 1425 hours (hrs), the home submitted a CIS related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS indicated that on an identified date, at 1600 hrs, resident #025 had an unwitnessed fall resulting in hospitalization.

Record review of progress notes revealed that on an identified date, at 1600 hrs, RPN #106 heard a loud noise and the resident was heard calling out from his/her bedroom. The RPN attended to the resident and found him/her lying on the floor with his/her mobility device overturned. Resident #025 sustained injury to an identified area. Review of progress note revealed resident was still in the hospital with an injury.

Interviews with PSW #104 and RPN #106 stated that the resident had been newly admitted to the home prior to the incident. They stated that resident #025 was at high risk

for falls. The resident used a mobility device to ambulate, but had to be reminded frequently to use the mobility device.

Record review of progress notes revealed resident #025 had been admitted to the home on an identified date, and sustained three unwitnessed falls with no serious injuries.

Record review of resident #025's post fall assessment huddle documentation sheets signed by the registered staff revealed the following:
On an identified date, preventative measures indicated two specified interventions.
On an identified date, preventative measures indicated the two specified interventions, plus a referral if useful.
On an identified date, preventative measures indicated the elimination of one specified intervention and the addition of one new intervention.

Record review of progress notes indicated the Occupational Therapist (OT) had seen the resident and recommended five interventions.

Record review of resident #025' written plan of care revealed that the falls section in the written plan of care had been initially created on an identified date.

Interview with the back-up Resident Assessment Instrument (RAI) co-ordinator stated that the falls section on resident #025's written plan of care had been initiated on an identified date, following resident #025's fourth fall in the home. He/ she further indicated that the written plan of care should have been updated with the preventative strategies from the post fall assessment huddles after each fall.

There was no information obtained to indicate that resident #025's plan of care set out the planned care for the resident, the goals the care was intended to achieve, and clear directions to staff related to falls, prior to resident #025's fall on an identified date.

Interview with the Director of Care (DOC) stated that the resident's plan of care should be based on the post fall assessment huddles and the falls prevention intervention recommendations from other disciplines. He/ she further indicated that if the resident was identified as high risk for falls, a written plan of care related to falls should have been developed. [s. 6. (1)]

2. 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.

On an identified date, the home submitted a Critical Incident System Report (CIS) reporting an allegation of abuse.

Interview with PCA #101 reported that he/she is the primary PCA for the resident on day shift. PCA #101 reported that on an identified date, he/she was providing personal care to the resident. PCA #101 reported that while the resident was sitting up in the bed, he/she transferred the resident from the bed into the wheelchair without a second person assisting. PCA #101 reported that noticed an injury on an identified body part and he/she reported to RPN #102.

Review of the plan of care states the resident requires two staff to transfer the resident in and out of bed and wheelchair.

Interview with nurse manager #103, revealed that staff were interviewed related to the incident, and found that the PCA #101 transferred the resident from bed to chair without a second person assisting. The resident was also noted on that day to have an injury to the identified area. The nurse manager confirmed that the care set out in the plan of care was not provided to resident #009 as specified in the plan. [s. 6. (7)]

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

On an identified date, the home submitted a Critical Incident System Report (CIS) reporting and allegation of abuse. On an identified date while leaving the dining room, resident #004 pushed resident #005, causing the resident to fall which resulted in resident #005 having an injury.

The home's Dementia Observation system/Behaviour tracking tool was initiated on an identified date, and the home's expectation was for the PCA to document resident #004's behaviours every 30 minutes on day, evening and night shifts.

Record review of resident #004's Dementia Observation system/Behaviour tracking tool dated from an identified time period revealed the resident's behaviours were not documented every thirty minutes.

Interviews with registered staff #116 and the DOC confirmed that documentation was not completed to track the resident's behaviours on the identified dates. [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 there was a written plan of care for each resident that set out the planned care for the resident; the goals the care was intended to achieve; and clear directions to staff and others who provided direct care to the resident, 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 care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

Review of the home's policy titled "Zero Tolerance of Abuse and Neglect Policy #RC-0305-00" published on January 8, 2016, indicated under investigation and reporting procedure: "Inform the Nurse Manager/ RN-in-Charge immediately once an allegation, suspicion or witnessed of abuse and/or neglect has been made (this includes informing the on-call manager) RN/RPN".

On an identified date, the home submitted a CIS reporting an allegation of abuse.

Review of progress note on an identified date, resident #024 told staff that an identified area was injured. Range of Motion (ROM) was very limited and identified area was indicative of a change in status. The resident also complained of pain on the same area. The resident told staff that he/she sustained it while staff was giving care. Incident report made. The physician was informed with new orders.

Interview with PCA #134 stated that on an identified date, when he/she came in the morning to provide care to resident #024, the resident showed his/her injured area. The resident told the PCA that two staff did this to him/her. PCA#134 stated he/she perceived it as an allegation of abuse, and he/she reported it to RN #144.

Inspector attempted to interview RN #144 and Nurse Manager (NM) #103, however, they were not available at the time of the inspection.

There was no information obtained to indicate that RN #144 reported the incident to NM #103.

Interview with the Administrator stated that the incident was considered as an allegation of abuse, and that it should have been reported by the RN to the nurse manager. The Administrator acknowledged that the home's policy was not complied with. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

On an identified date, the home submitted a CIS to the Director of an allegation of abuse.

Record review of Central Intake Assessment and Triage Team (CIATT)'s pager report indicated that the incident occurred on an identified date, and reported to CIATT two

days after.

Record review of resident #023's progress notes indicated that the resident's family members were upset and reported to RN #107 of an injury to the resident. Progress note further stated that the resident's family member wanted to know who had done this to the resident.

Interview with RN #017 stated that he/she had worked on the identified date, and observed an injury on resident #023 at the beginning of evening shift, when the resident's family had brought into his/her attention. He/she further confirmed that the family was upset and wanted to know if another resident had caused the injury to the resident.

Review of home's policy titled Zero Tolerance of Abuse and Neglect (Policy# RC-0305-00, Published on January 08, 2016) indicated under investigation and reporting that RN In- charge/ DOC/Administrator to notify MOHLTC immediately that an alleged, suspected or witnessed incident of abuse or neglect has become known and an investigation is underway.

Review of the schedule provided by the home for the evening shift of the identified date, indicated that RN #107 had been RN in- charge in the building on the identified date and the former DOC #154 had been the on call manager.

Interview with RN #107 indicated that he/she had been the RN in charge and most responsible person on the identified date, evening shift as it was a weekend. The RN further indicated that he/she did not call the former DOC #155 to notify of the above mentioned incident.

Interview with the former DOC #155 indicated that at the time of above mentioned incident RN In charge would have been most responsible person to contact MOHLTC after hours and on call manager. The DOC further confirmed that he/she could not recall being notified by telephone on the identified date, about the incident by RN #107.

Interview with the Administrator of the home indicated that as per home's policy on Abuse and Neglect, RN in charge had responsibility to inform the on call manager when he/she had been notified of any alleged abuse of residents. He/she further indicated by reviewing resident #023's progress notes that on the identified date, the incident of alleged abuse should had been notified immediately to MOHLTC by RN in charge or the

on call manager, and the home did not notify as required. [s. 24. (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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning device or techniques when assisting residents.

On an identified date, the home submitted a Critical Incident System Report (CIS) reporting an allegation of abuse.

Interview with PCA #101 reported that he/she is the primary PCA for the resident on day shift. PCA #101 reported that on the identified date, he/she was providing personal care to the resident. PCA #101 reported that while the resident was sitting up in the bed, he/she transferred the resident from the bed into the wheelchair without a second person assisting. PCA #101 reported that noticed an injury to an identified resident's body and he/she reported to RPN #102.

Review of the plan of care states the resident requires two staff to transfer the resident in and out of bed and wheelchair.

Interview with nurse manager #103, revealed that staff were interviewed related to the incident, and found that on the identified date, PCA #101 transferred the resident from bed to chair without a second person assisting. The resident was also noted on that day to have a injury . The nurse manager confirmed that PCA #101 did not use safe transferring techniques when assisting resident #009. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored was kept locked at all times, when not in use.

On an identified date, the following observations were made:

At 1620 hrs, the inspector entered an identified unit and observed a medication cart located in front of an identified resident room to be unlocked and unsupervised. The inspector was able to open the cart and gain access to the medications contained inside. RPN # 106, who was assigned to the medication cart was located in the medication room where there is no visibility to the medication cart. At 1624 hrs, RPN #106 returned to the cart and was unaware that the medication cart was left unlocked.

On an identified unit at 1649 hrs, the inspector and PCA # 110 witnessed the medication cart to be unlocked and unsupervised and stored in the hallway. RPN #109, who was assigned to the medication cart was located inside of a resident's room and not within close proximity of the medication cart. At 1651 hrs, RN #109 returned to the cart and confirmed that he/she is aware that the medication cart was left unlocked.

Interviews held with RPN #'106, #110, nurse manager #103, DOC and the Administrator confirmed that the medication cart(s) should be locked at all times when not in use and unsupervised. [s. 130. 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 steps are taken to ensure the security of the drug supply, including the following: 1. All areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

On an identified date, the home submitted CIS to the Director of an allegation of abuse. Further review of the CIS did not indicate results of the abuse and neglect investigation.

Record review of the letter provided to resident #023's family member stated that the home had started investigation with all of the staff that were involved in the residents care regarding the incident of alleged abuse. The letter did not indicate any date.

Interview with PSW#146 and RN #116, revealed that the home had conducted an investigation on resident #023's injury reported by his/her family on an identified date. The PSW and RN had been involved in the home's investigation at that time.

Interview with the home's former DOC #154 indicated that he/she could not recall the results of the home's investigation, and if results had been reported to the MOHLTC for the above mentioned CIs.

Interview with the Administrator indicated that as per the home's expectation the results of the abuse or neglect investigation should have been reported to the Director by the DOC, Nurse Manger or Administrator of the home. He/she further confirmed that the home did not report the results of the abuse or neglect investigation for the above mentioned CI as required. [s. 23. (2)]

2. On an identified date, the home submitted a CIS reporting an allegation of abuse.

Review of the CIS report revealed that on an identified date, at 1635 hrs, Nurse Manager (NM) #103 documented on the CIS report that staff investigation was ongoing. The CIS report was last amended on two days after, at 1703 hrs and the outcome of the investigation was not included.

Inspector attempted to interview NM #103, however, he/she was not available at the time of the inspection.

Interview with the Administrator acknowledged that the home did not report the results of the abuse investigation to the Director, as NM #103 did not amend the CIS with the results of the abuse investigation. [s. 23. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in extended class attending the resident and the pharmacy service provider.

The licensee submitted the following critical incident system (CIS) reporting an incident of improper care/treatment that resulted in a risk to resident #013 relating to medication incidents:

On three identified dates, the home submitted CIS to the Director reporting an incident of

improper care/treatment that resulted in a risk to resident #013.

A review of the resident's health record including progress notes, professional advisory committee (PAC) meeting minutes and the home's investigative notes revealed and interviews held with a nurse manager, the DOC and the Executive Director confirmed that there was no documented report available to support that immediate actions were taken to assess and maintain the resident's health or that the medication incidents were reported to the DOC, Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

This inspection was conducted concurrently with complaint inspection #2017_378116_0008 related to the medication incidents involving resident #013.
An area of non-compliance is being issued under s.131 under inspection report #2017_378116_0008. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed and a written record is kept of everything required under clauses (a) and (b).

The licensee submitted the following critical incident system (CIS) reporting an incident of improper care/treatment that results in a risk to the resident relating to medication incidents involving resident #013:

On three identified dates, the home submitted a CIS to the Director reporting an incident of improper care/treatment that results in a risk to resident #013

A review of the resident's health record including progress notes, professional advisory committee (PAC) meeting minutes and the home's investigative notes revealed and interviews held with a nurse manager, the DOC and the Executive Director confirmed that there was no written record available to support that the above mentioned medication incidents were reviewed and analyzed.

This inspection was conducted concurrently with complaint inspection #2017_378116_0008 related to the medication incidents involving resident #013.
An area of non-compliance is being issued under s.131 within inspection report #2017_378116_0008. [s. 135. (2)]

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Issued on this 10th day of July, 2017

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

Original report signed by the inspector.