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 21, 2017	2017_378116_0008	024580-16, 027494-16, 034531-16, 034897-16	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

SARAN DANIEL-DODD (116)

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): April 26, 27, 28 & May 1, 2, 4, 5, 8, 9, 10, 11, 12, 17, 25, 26, 29, 2017.

During the course of the inspection, the inspector observed home areas, staff to resident interactions, medication administration, reviewed resident health record, staff training records, homes internal investigation notes, complaints binder and applicable policies and procedures.

A written notification (WN) under O. Reg.79/10, s. 135, identified in this inspection will be issued under critical incident inspection #2017_659189_0009 that was simultaneously inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Director of Care (DOC), attending physician, nurse manager(s), minimum data set resident assessment instrument coordinator (MDS-RAI), registered staff members, physiotherapist, personal care attendants (PCA), representative from an external provider, resident #013 and an identified individual.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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).

Findings/Faits saillants :

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

On an identified date, the home submitted a critical incident to the Director reporting an incident. The CIS read as follows:

A resident complained to an identified individual that an identified staff member provided care in an identified manner.

The written plan of care in place on an identified date, states that the resident is totally dependent of two staff for identified care tasks.

Review of the homes internal investigation notes revealed and interview held with PCA #128 confirmed that on an identified date, PCA #128 provided the resident with an identified care task without the assistance of another staff member. PCA #128 denied assertions of providing care in an identified manner to resident #013. PCA #128 states that the identified care task was provided to the resident as a diversion however, the diversion was unsuccessful.

Further interview held with the nurse manager and the DOC confirmed that the care set out in the plan of care in relation to the identified care task was not provided to resident #013 as specified in the plan. [s. 6. (7)]

2. On an identified date, the licensee submitted a CIS reporting to the Director an incident that caused an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status. A subsequent CIS was submitted to the Director on a separate date, reporting to the Director an incident of improper/incompetent care that results in harm or risk to a resident. The CIS reports read as follows:

- resident #013 had been experiencing identified symptoms from an identified date, after an incident that resulted in an injury. On an identified date, resident #013 was assessed by the physician and provided with a confirmed diagnosis. An identified test was ordered which disclosed an identified injury however, the results were received approximately two weeks after the performed test.

- correspondence was received from an identified individual stating that resident #013 had an incident while staff performed an identified task. The identified individual stated that the incident was not reported to the registered staff and an incident report was not completed. A physician assessed and diagnosed resident #013 with an identified condition. Treatment was initiated.

Review of the correspondence that was received by the home on an identified date, indicates that resident #013 stated that PCA staff #130 performed an identified task without the assistance of another staff member when an incident occurred. A review of resident #013's progress notes, 24 hour report and incident reports for a specified period did not include any documentation and/or findings of an incident that occurred on or around the specified date. An interview was held with PCA staff #130 who denied the assertions of performing the identified task to resident #013 without the assistance of another staff member.

Review of the progress notes for an identified period, document entries where the resident experienced identified symptoms. On an identified date, the physician reassessed the resident and initiated treatment for the confirmed diagnosis which included a requisition for an identified test and identified medication therapy.

A review of the physician's order for a specified date, and an interview held with representatives from an external provider confirmed that the physician's order was received and processed to complete the requested test.

The homes policy (#NU-0901-03) directs staff to do the following:
- Note date of service on requisition tracking form for the unit
- Record date results received on requisition tracking form
- Nurse to check identified requisition tracking form three times per week to verify that work was taken and results returned; contact immediately for any discrepancies.

Upon review of the requisition tracking form for the unit it was discovered that the requisition for resident #013 was not entered in the log. Review of the resident's health record and progress note for a specified date, indicated that a follow up regarding the identified requisition was not conducted until 12 days after; whereby it was identified that the external provider was in the home on an identified date, but was unable to see resident #013.

Interviews held with representatives from the external provider, registered staff members, a nurse manager and the DOC acknowledged that a reasonable time frame for completion of requisition services has not been established however, registered staff member(s) of the home should have conducted a follow up promptly to avoid delay in providing care to resident #013. Further interview with a nurse manager, DOC, attending physician and the E.D. confirmed that the care set out in the plan of care in relation to

identified requisitions was not provided to resident #013 as specified in the plan. [s. 6. (7)]

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 was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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, has the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On an identified date, the licensee submitted a CIS to the Director reporting 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 heath status.

Review of the progress notes for an identified date, indicate that while an identified task was being provided for resident #013 an incident occurred which resulted in an injury. The resident was transferred to the hospital and returned the same day.

Interviews held with PCA staff #'s 110 and #133 stated that while they were attempting to perform the identified task, resident #013 continued to display identified behaviours which played a factor in the sustained injury. The PCA's stated that they positioned resident #013 in an identified location.

Review of the homes identified policy (#RC-0518-21) defines an identified incident as following: any unintentional change in position where the resident ends up on the floor, ground or other lower level.

Interviews held with RPN staff #139 and #173 indicated that a post fall assessment is to be completed after each incident of a fall and a post fall assessment was not conducted using a clinically appropriate assessment instrument. Further interviews held with a nurse manager and the DOC confirmed that a post-fall assessment should have been conducted after the incident. [s. 49. (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 when a resident has fallen, has the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for fall, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On an identified date, the licensee submitted a CIS reporting an incident of improper/incompetent treatment that results in harm or risk to a resident to the Director. The CIS read as follows:

On an identified date, resident #013 was to receive an identified medication and the nurse administered the medication in an identified form when the directive stated that the medication is not to be administered in an identified form.

Resident #013 was admitted to the home with an identified diagnosis that requires an identified medication therapy to manage the identified condition.

Review of the medication administration record (MAR) and physician order for a specified period directs staff to administer the medication in an identified form with the following directive documented on the MAR: "hazardous, high alert, do not provide in an identified form".

An interview held with registered staff (RN) #107 indicated that he/ she was assigned to provide coverage on an identified unit. RN staff #107 indicated that this was not their regularly assigned unit. RN #107 stated that prior to commencing the medication pass he/she asked resident #013 whether they could consume the identified medication in an altered the form and resident #013 agreed. RN #107 altered the form of the identified medication and mixed it in an identified substance.

Interview held with RN #107 confirmed being aware that the medication had a high alert

and instructions not to administer in an identified form however, he/she altered the form as was unaware if consuming the pills in an identified form would pose an identified risk to the resident. [s. 131. (2)]

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

On an identified date, the home submitted a CIS to the Director reporting an incident of improper care/treatment regarding medication administration. The CIS read as follows:

- Received a written complaint from an identified individual reporting that an identified medication was not administered as per the physician's order.

Review of the MAR for an identified period indicates that on a specified date, the physician changed the administration times for an identified medication over a two day period and further changed the dose for a specified period.

Review of the homes internal investigation notes and an interview held with registered staff #131 indicated that on a specified date, registered staff #131 administered the identified medication between a specified time to resident #013.

Reviewed the homes policy (#01-04-2016, section 2) which directs staff to administer time critical scheduled medications within 30 minutes (before or after) of the scheduled time. All other medications must be administered 60 minutes before or after the scheduled time.

During an interview, RPN staff #131 indicated being aware of the change in administration time however, did not take steps to verify the accuracy of the medication order. Further interviews held with RPN staff #131, a nurse manager and the DOC confirmed that on the specified date, resident #013 was not administered a specified dose of the identified medication in accordance with the directions for use specified by the prescriber.

On a separate date, the home submitted a CIS to the Director reporting an incident of improper care/treatment that results in a risk to the resident. The CIS read as follows:

- The resident is prescribed an identified medication and was to receive the medication for an established period. On an identified date, it was noted that the medication was

previously stopped on an identified date. The resident appears to have been without the identified medication for six days.

Review of the physician's order and medication administration record (MAR) for an identified date, documents that the identified medication was to be given at specified times over an identified duration. Review of the MAR sheet indicates a line was drawn through over a 16 day period for established administration times.

Review of the homes internal investigation notes and interviews held with registered staff #'s 135, 106, 131, 132 did not determine the rationale for the discontinuation of the identified medication. Further interviews held with the above-mentioned staff and a nurse manager and the DOC confirmed that the identified medication was not administered to resident #013 in accordance with the directions for use specified by the prescriber.

During an interview, an identified individual reported to the inspector concerns regarding resident #013 not receiving an identified medication as ordered.

Resident #013 has a confirmed diagnosis that requires the use of medication. Review of the MAR for an identified period and physician's order directs staff to apply and remove the identified medication at established times.

Review of the homes internal investigation notes, MAR and an interview held with RPN staff #131 indicated that the identified medication was not administered to the resident on an identified date. Further interview held with RPN staff # 131, a nurse manager and the DOC confirmed that the identified medication was not administered to resident #013 on an identified date, in accordance with the directions for use as specified by the prescriber.

Registered staff # 131 was disciplined as a result of the above mentioned medication incidences. The above mentioned medication incidences did not result in harm to resident #013 [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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.