Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 7, 2020	2019_642698_0018	011344-19, 011345-19, 013500-19, 014486-19, 018521-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

ORALDEEN BROWN (698)

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): November 19-22, 25-29, December 2-6 and 9, 2019.

The following Critical Incident System (CIS) intakes were inspected during this inspection:

Log #018521-19, M612-000025-19; log #013500-19, M612-000021-19 related to falls;
Log #014486-19, M612-000022-19 related to multiple care areas.

The following follow-up to compliance order intakes were inspected during this inspection:

Log #011344-19 related to Compliance Order (CO) #001, issued to the licensee on May 23, 2019, within the inspection report #2019_766500_0012 under the LTCHA, 2017 c.8. s. 6. (7) Plan of Care, was inspected.

Log #011345-19 related to Compliance Order (CO) #002, issued to the licensee on May 23, 2019, within the inspection report #2019_766500_0012 under the LTCHA, 2017 c.8. s. 6. (11) Reassessment and revision of the Plan of Care, was inspected.

This non-compliance occurred prior to the compliance due date on September 30, 2019 for a previous inspection #2019_766500_0012. Therefore a Written Notice (WN) was issued instead.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Practical Nurse (RPN), Physiotherapist (Physio), Personal Support Worker (PSW), residents and family members.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

1 WN(s)
0 VPC(s)
0 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (11)	CO #002	2019_766500_0012	698
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_766500_0012	698

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	Légende 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 was provided to the resident as specified in the plan.

On a specified date, the Ministry of Long-Term Care (MLTC) received a Critical Incident Systems (CIS) report from the home, related to injuries of unknown cause where resident #004 was found with injuries.
Record review of the CIS report revealed that on a specified date and time, resident #004 was discovered by Personal Support Workers (PSW) #112 and #113 in their room sitting in wheelchair, with injuries to an identified body part. Resident's face was beet red and they were noted to be in severe respiratory distress. PSW #112 with the assistance of PSW #113 transferred resident #004 back to bed using a specified type of lift upon request of Registered Practical Nurse (RPN) #111. The resident was transferred to hospital the same day and returned to the home at a later date with a specified diagnosis.

Review of resident #004's care plan, with a specified review date, indicated that a specific type of lift was required for transfers.
Review of the home's investigation notes revealed that the home's surveillance camera captured events on an identified date and time, where staff #112 was seen with staff #113 entering the resident's room with a specific type of lift.

Interview with PSW #112 revealed that they were the primary caregiver for resident #004 on a particular day and took them to their room after meal service. After some time, PSW #112 went back with PSW #113 to provide personal care. Upon entering the room, PSW #112 stated that the resident was experiencing respiratory distress and PSW #113 ran for help. PSW #112 explained that they were asked to transfer the resident from their wheelchair back to bed immediately by RPN #111. They stated that they used a specific type of lift to transfer the resident back to bed.

Interview with PSW #113 revealed that they were assisting PSW #112 with resident #004 on a specified date and upon opening the door and entering the resident's room at a specified time, they observed that the resident was sitting in their wheelchair, in the dark, facing the window; and that they could hear resident #004 breathing heavily and appeared to be in distress. PSW #113 stated that they saw something on the resident's body part and upon touching it, noted that it was blood. PSW #113 immediately left PSW #112 in the room with the resident and ran for help, returning with RPN #111 who completed assessments. PSW #113 stated that they were asked to put the resident back to bed and that they used the lift that was brought into the room by PSW #112. When asked if they were aware of the resident's care plan, PSW #113 stated that they were not aware of the resident's transferring requirements as the resident was not assigned to

them. PSW #113 stated that resident #004 was assigned to PSW #112 and they were just assisting them with transferring at the time. They indicated that it was their expectation for PSW #112 to know the correct mechanical device they were using for their residents according to the care plan. PSW #113 acknowledged that they did not question PSW #112's action due to the urgency of the situation that was unfolding, with the resident being in distress.

Interview with RPN #111 revealed that they were providing care for another resident when PSW #113 came to them in a panic regarding resident #004. Upon entering resident #004's room, RPN #111 observed that the resident was in distress with visible signs of injury. RPN #111 assessed the resident and requested that PSW #112 and #113 transfer the resident back to bed. RPN #111 called the Registered Nurse In Charge (RNIC) for help who alerted first responders, and the resident was transferred to hospital for medical attention.

Interview with DOC #106 revealed an investigation was conducted by the home and that PSW #112 used an incorrect type of lift to transfer resident #004 on the above mentioned date, and did not provide care as specified in their care plan. PSW #112 was disciplined, provided retraining and was transferred to another unit.

This non-compliance occurred prior to the compliance due date on September 30, 2019 for a previous inspection #2019_766500_0012. [s. 6. (7)]

Issued on this 13th day of January, 2020

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

Original report signed by the inspector.