Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
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Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: November 21, 2024
Original Report Issue Date: November 1, 2024
Inspection Number: 2024-1607-0003 (A1)
Inspection Type: Complaint Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: Wesburn Manor, Etobicoke

AMENDED INSPECTION SUMMARY

Non-compliance NC #003, Written Notification: Housekeeping, was amended to clarify wording related to the interview with Assistant Administrator #119 related to environmental cleaning. Non-compliances #001 and #002, are included in this report for reference, however, were not amended.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 7, 9, 10, 11, 15, 16, 17, 18, 23, 2024

The following intakes were inspected:

- Intake: #00120850 – Critical Incident (CI) – related to fall of resident resulting in injury
- Intake: #00126397 – CI – related to outbreak
- Intake: #00127147 – CI – related to alleged abuse from staff to resident
- Intake: #00127957 – CI – related to injury of unknown cause sustained by resident
- Intake: #00123567 - Complaint related to environmental temperatures

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

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.

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

Summary and Rationale

On a specified date, the resident presented with altered skin integrity and subsequently was diagnosed with an injury.

Review of the resident's written plan of care indicated the resident required a specific level of care in activities of daily living (ADL) with certain number of staff. Interview with staff indicated that sthey did not follow the resident's written plan of care to provide care as per the plan.
Interview with the Nurse Manager (NM) and the Director of Care (DOC) indicated

staff were expected to provide care as per the resident's written plan of care.

Failure to provide care to a resident as per their written plan of care could lead to an increased potential for injuries.

Sources: CI report, resident clinical record, interviews with home's staff.
[210]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions were taken to respond to the needs of the resident responsive behaviours, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Summary and Rationale

On a specified date it was witnessed by a family member that the staff was not gentle when providing a specific care to the resident. The resident presented with responsive behaviour and sustained altered skin integrity.

Interview with staff indicated that the resident had an identified responsive behaviour when being provided the specific care.

Review of the clinical record indicated the resident had an identified responsive behaviour multiple times during several months. There was no referral sent to the Behavioural Support Ontario (BSO) lead for further assessment of the resident's behaviour.

Review of the resident's written plan of care for responsive behaviour indicated staff to approach the resident in a specific manner. The plan of care did not indicate interventions for the specific care behaviour.

As per the home's policy Responsive Behaviours Management, RC-0517-00, from September 05, 2022, for new or escalating behavioural expression, the care team will report to Registered Nurse (RN)/Registered Practical Nurse (RPN), document in Point of Care (POC), the registered staff will assess the resident and determine the need for additional pharmacological or nonpharmacological, care interventions.

Interview with the BSO lead and NM indicated that when the resident presented with the specific care behaviour, staff were expected to send a referral for the resident's behaviour to be reassessed.

Failure to reassess the resident's responsive behaviour and implement interventions to respond to these behaviours poses the risk of not managing the resident's behaviour.

Sources: CI report, progress notes, investigation records; interviews with home's staff.
[210]

(A1)

The following non-compliance(s) has been amended: NC #003

WRITTEN NOTIFICATION: Housekeeping

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(iii) contact surfaces;

The licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfection of the contact surfaces in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Summary and Rationale

The home had been declared in outbreaks on five occasions in 2024.

Interviews with several environmental staff indicated that they did not clean the high-touch areas in the assigned home areas with a low-level disinfectant in

accordance with evidence-based practices, at least daily when the home was not in outbreaks. During outbreaks there were dedicated people performing cleaning of high-touch areas at least twice daily.

As per the Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, from April 2018, high-touch surfaces in care areas require more frequent cleaning and disinfection than minimal contact surfaces. Cleaning and disinfection should be performed at least daily and more frequently if the risk of environmental contamination is higher.

A review of the home's policy Risk Stratification Matrix to Determine the Cleaning Frequency of Specific Areas, BS-0300-00, Appendix A, from January 3, 2020, adapted from PIDAC: Best Practices for Environmental Cleaning for Infection Prevention and Control (2018), to determine cleaning frequencies based on total score of physical environments in LTC home, indicated that the total risk score of four to six required cleaning at least daily. The risk score was calculated as a summary of probability of contamination with pathogens (1-3); potential for exposure (high touch -three, low touch surfaces-one) and vulnerability of population to environmental infection (less susceptible-zero, more susceptible-one). High-touch surfaces alone have score of three. High-touch surfaces are defined as those that have frequent contact with hands. Examples included doorknobs, telephone, call bells, bedrails, light switches, bedside tables, dressers, wall areas around the toilet and edges of privacy curtains.

Interview with Infection Prevention and Control (IPAC) lead indicated that high-touch areas including handrails and door-knobs on residents' units have to be cleaned with low level disinfectant on a daily basis, and twice daily during outbreaks.

Interview with Environmental Services Supervisor indicated that it was an expectation from environmental cleaning staff to clean high touch areas.

Failure of the home to clean the high-touch surfaces, using at a minimum a low-level disinfectant, at least daily, could lead to increased infections in the home.

Sources: Home's policy BS-0300-00, from January 3, 2020, interviews with home's staff.
[210]