Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 14, 16, 21, 22, 24, 28, Mar 9, Apr 2, 3, 2012	2012_07649 _0003	Complaint

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
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

BAMBO OLUWADIMU (149)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Nurse Manager, Manager for Programs and Services, Housekeeping Supervisor, Registered staff, Personal Support Workers (PSWs), Recreation Services Assistance and residents' families.

During the course of the inspection, the inspector(s) walk through the Resident Home Areas and observed staff to resident interaction, reviewed licensee's policies to promote zero tolerance of abuse and neglect of residents, policy on managing and reporting complaints, reviewed licensee's abuse prevention training materials, complaints documented records, resident's records and administrative records.

PLEASE NOTE:
1. Non compliance s.20 (1), findings #1 issued under this inspection was found under Inspection # 2012_07649_007.
2. Non compliance s.19 (1), findings #1 issued under this inspection was found under Inspection # 2012_07649_007.
3. Non compliance s.24 (1), findings #1 issued under this inspection was found under Inspection # 2012_07649_007.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee did not ensure that residents are protected from abuse and are not neglected by the licensee or staff.

On November 16, 2011, PSW A did not provide continence care for resident #1 between 0700h and 1200h when resident #1 was showered. Resident #1's incontinence brief was so wet that the urine leaked through resident #1's clothes to the wheelchair seat cover, socks and shoes. After PSW A showered resident #1, resident #1 was put back into the wheelchair without changing or cleaning the wheelchair seat cover. PSW A proceeded to dress resident #1 in fecal stained pants, urine soaked socks and urine soaked shoes. When PSW A was providing care for resident #1, PSW A also neglected to put gloves on resident #1 as specified in the resident's plan of care. As a result, resident #1 scratched himself/herself and blood stains were later discovered on the incontinent brief [s. 19 (1)].
2. On resident #2's shower days, the assigned PSW takes resident #2's personal shower items, nightwear and linens to the shower room before advising resident #2 to come to the shower room for a bath. On July 4, 2011, PSW A instructed resident #2, who self propels the wheelchair, to get the nightwear from the room. Resident #2 was so fearful and intimidated that resident #2 immediately complied. Resident #2 reported the alleged abuse incident to RPN A and resident #2's daughter. The investigation for the alleged abuse incident commenced on August 9, 2011 [s. 19 (1)].

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 subsections:

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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Licensee did not comply with its policy that promotes zero tolerance of abuse and neglect of residents. The neglect of resident #1 on November 16, 2011 was not reported according to the licensee' policy, Resident Abuse and Neglect: Investigating and Reporting (RC-0305-02) [s. 20(1)].
2. Licensee did not comply with its policy to promote zero tolerance of abuse and neglect of residents. The incident of alleged abuse on July 4, 2011 was not investigated and reported according to the licensee' policy, Resident Abuse and Neglect: Investigating and Reporting (RC-0305-02)[s. 20(1)].
3. Licensee's policy to promote zero tolerance of abuse and neglect of residents (Zero Tolerance for Abuse and Neglect (RC-0305-00), Resident Abuse and Neglect: Investigation and Reporting (RC-0305-02) and Education and Awareness on Prevention of Resident Abuse and Neglect (RC-0305-01)) did not contain an explanation of the duty under section 24 of the Act to make mandatory reports [s. 20(2)(d)].

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 its policy to promote zero tolerance of abuse and neglect of residents contain an explanation of the duty under section 24 of the Act to make mandatory reports and is compliant with this policy, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee did not investigate and respond within 10 business days of the receipt of the complaint. Resident #2 and resident #2's daughter complained to RPN A about an alleged abuse incident on July 4, 2011. When resident #2's daughter did not get a response from the home, a complaint letter was sent to the home. Letter was received by the home's Administrator August 9, 2011. An investigation commenced August 12, 2011 [r.101(1)1].
2. Licensee' documented record for the complaint letter dated July 7, 2011 did not include the date the complaint was received, the type of action taken to resolve the complaint (the date of the action, time frames for actions to be taken and any follow-up action required) and every date on which any response was provided to the complainant and a description of the response [r. 101 (2)].

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee did not submit to the Director, a copy of the written complaint related to section 24 of the Act, along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).

Complaint letter dated July 7, 2011 was forwarded to the Director by the complainant. The licensee did not submit to the Director, a copy of the complaint letter dated July 7, 2011 or the response to the letter [r. 103 (1)].

WN #5: 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 subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Licensee did not immediately report an alleged abuse and neglect of a resident to the Director.

Resident #1's daughter reported an alleged neglect of resident #1 on November 17, 2011 to the Nurse Manager. The Nurse Manager did not immediately report the alleged neglect of resident #1 by PSW A to the Director [s. 24 (1)].
2. RPN A was informed by resident #2 about an alleged abuse incident on July 4, 2012. RPN A did not report the incident to the Director. The complaint letter about the alleged abuse was received by the Administrator on August 9, 2011, The Administrator did not report the incident to the Director. A Critical Incident report was not sent to the Director through the Critical Incident System [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 that the following are immediately reported 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006, to be implemented voluntarily.

Issued on this 4th day of April, 2012

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

(149)

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BAMBO OLUWADIMU (149)
Inspection No. / No de l'inspection :	2012_07649 _0003
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Feb 14, 16, 21, 22, 24, 28, Mar 9, Apr 2, 3, 2012
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	WESBURN MANOR 400 The West Mall, ETOBICOKE, ON, M9C-5S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~JUDI JOLLIFFE~~ (ACTING) Rosemary Stckar

To TORONTO LONG-TERM CARE HOMES AND SERVICES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare and submit a plan to the Ministry of Health by April 20, 2012 outlining how the licensee will ensure that residents are protected from abuse by anyone and residents are not neglected by the licensee or staff. The plan shall be implemented by June 29, 2012.

Grounds / Motifs :

1. On resident #2's shower days, the assigned PSW takes resident #2's personal shower items, nightwear and linens to the shower room before advising resident #2 to come to the shower room for a bath. On July 4, 2011, PSW A instructed resident #2, who self propels the wheelchair, to get the nightwear from the room. Resident #2 was so fearful and intimidated that resident #2 immediately complied. Resident #2 reported the alleged abuse incident to RPN A and resident #2's daughter. The investigation for the alleged abuse incident commenced on August 9, 2011. (149)
2. On November 16, 2011, PSW A did not provide continence care for resident #1 between 0700h and 1200h when resident #1 was showered. Resident #1's incontinence brief was so wet that the urine leaked through resident #1's clothes to the wheelchair seat cover, socks and shoes. After PSW A showered resident #1, resident #1 was put back into the wheelchair without changing or cleaning the wheelchair seat cover. PSW A proceeded to dress resident #1 in fecal stained pants, urine soaked socks and urine soaked shoes. When PSW A was providing care for resident #1, PSW A also neglected to put gloves on resident #1 as specified in the resident's plan of care. As a result, resident #1 scratched himself/herself and blood stains were later discovered on the incontinent brief. (149)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 29, 2012

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
~~55 St. Clair Avenue West~~
~~Suite 800, 8th Floor~~
~~Toronto, ON M4V 2Y2~~
~~Fax: 416-327-7603~~

1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of April, 2012

Signature of Inspector / Signature de l'inspecteur : (149)

Name of Inspector / Nom de l'inspecteur : BAMBO OLUWADIMU

Service Area Office / Bureau régional de services : Toronto Service Area Office