Ontario

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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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 16, 22, 23, 24, Mar 1, 6, 9, 15, Apr 2, 3, 4, 2012	2012_07649 _0006	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 Nurse Manager, Registered staff, Personal Support Workers (PSWs) and residents' families.

During the course of the inspection, the inspector(s) observed resident care, reviewed residents' records, reviewed responsive behaviour training materials, reviewed home's complaint documented records and administrative records.

PLEASE NOTE:
1. Non-compliance s. 6(1)(c), findings #7 and #8, and s. 6(8), findings #6 issued under this inspection were found under Inspection # 2012_07649 _0005.

2. Non-compliance s. 6(1)(c), findings #3 and #4, and s. 6(8) findings #1, #2, #5 and #6 issued under this inspection were found under Inspection # 2012_07649 _0007.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

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. 6. Plan of care

Specifically failed to comply with the following subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee did not ensure that residents' plan of care provided clear directions to staff and others who provide direct care to the residents; staff and others who provide direct care to the resident were not kept aware of the content and did not have convenient and immediate access to it.

Residents' written plans of care are kept in PSW binders on all Resident Home Areas for convenient and immediate access by staff. Resident A's plan of care for ADL assistance was not in the PSW binder on March 1, 2012. PSWs who provided direct care to the resident A were not given convenient and immediate access to the written plans of care [s.6. (8)].

2. Resident A was assessed to be totally dependent for transfer and required two staff for transferring. PSW B reported to the Inspector that he/she transferred resident A alone to and from the shower chair on November 16, 2011. PSW B was not aware of resident A's transfer requirements [s.6.(8)].

3. Preferred bath days on resident A's plan of care were Tuesdays and Fridays. Bath days on the bath list were Wednesdays and Saturdays. PSW A and PSW B reported to the inspector that resident A's bath days are Wednesdays and Saturdays. Resident A's plan of care did not provide clear directions to staff [s.6(1)(c)].

4. Resident G's plan of care for bathing did not include resident G's preferred bath time (days or evenings), bath days (days of the week) or bath type (shower or tub bath). The plan of care did not provide clear direction to staff [s.6(1)(c)].

5. PSW C assigned to resident G on November 28, 2011 on the day shift and PSW D assigned to resident G on November 28, 2011 on the evening shift both transferred resident G on their own. They were not aware of resident G's transfer requirements on the plan of care. Resident G required two staff for transferring [s.6 (8)].

6. Resident B prefers to be bathed by the private PSW. PSW E was on the bath team assigned to resident B on October 3, 2011 and was not aware of resident B's bath preference. When resident B refused to be bathed by PSW E, PSW E ignored resident B's response and proceeded to struggle with the resident B until resident B's private PSW intervened. PSW F who was assigned to resident B on Feb 29, 2012 was also not aware of resident B's bath preference to have the private PSW bathed him/her [s.6.(8)].

7. Resident B's shower days are Mondays and Thursdays evenings. On resident B's plan of care, the bath days were Tuesdays and Thursday evenings. Resident B's also prefers to be showered by the private PSW. The plan of care did not include this bath preference. The plan of care did not provide clear directions to staff [s.6.(1)(c)].

8. Resident C has been hypersensitive to odours since November 2010. The home developed strategies and interventions to help resident cope with this problem. These strategies were not included in resident C's plan of care as of Feb 27, 2011. The plan of care did not provide clear directions to staff [s.6.(1)(c)].

9. Annual care conference for resident F was held October 27, 2011. At the care conference, it was determined that resident F will be placed by the wall in the resident's lounge to prevent other residents from grabbing resident F's right arm. RPN A and PSW G who provided direct care to resident F were not aware of this care intervention [s.6.(8)].

10. Residents' written plans of care are kept in PSW binder on all Resident Home Areas for convenient and immediate access by staff. Resident F's plan of care in the PSW binder on February 23, 2012 was last updated on April 6, 2011. Computer version of the plan of care was last updated January 9, 2012. PSWs caring for resident F did not have convenient and immediate access to the current written plans of care [s.6.(8)].

11. Resident D has a responsive behaviour. The behaviour plan of care or ADL assistance plan of care did not include this behaviour and the strategies identified to handle this behaviour. The plan of care did not provide clear directions to staff [s.6.(1)(c)].

12. Resident E becomes physically aggressive when the hair is washed in the shower. The plan of care did not include this behaviour and the strategies identified to handle this behaviour. The plan of care did not provide clear directions to staff [s.6.(1)(c)].

13. Resident F has a responsive behaviour, which sometimes poses safety concerns for resident F and other residents on the unit. Resident F's plan of care did not include this behaviour and did not include the strategies put in place to deal with this behaviour [s.6.(1)(c)].

Additional Required Actions:

CO # - 001, 002 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. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee did not ensure that staff who provide direct care to resident receive training on mental health issues and behaviour management. Staff reported to the Inspector that they have not had recent training on behaviour management. Manager for Programs and Services (Acting) reported to the inspector that training on behavioural management and mental health issues was likely missed in 2011 because the home did not have a full-time Training Coordinator. Training record for 2011 did not contain training information on behaviour management and mental health issues [s.76.(7)2,3].

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 who provide direct care to residents receive training on mental health issues and behaviour management, to be implemented voluntarily.

Issued on this 4th day of April, 2012

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

(149)

Ontario

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 _0006
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Feb 16, 22, 23, 24, Mar 1, 6, 9, 15, Apr 2, 3, 4, 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 Stekar

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:

Ontario

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Order / Ordre :

The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Grounds / Motifs :

1. Residents' written plans of care are kept in PSW binder on all Resident Home Areas for convenient and immediate access by staff. Resident F's plan of care in the PSW binder on February 23, 2012 was last updated on April 6, 2011. Computer version of the plan of care was last updated January 9, 2012. PSWs caring for resident F did not have convenient and immediate access to the current written plans of care. (149)
2. Annual care conference for resident F was held October 27, 2011. At the care conference, it was determined that resident F will be placed by the wall in the resident's lounge to prevent other residents from grabbing resident F's right arm. RPN A and PSW G who provided direct care to resident F were not aware of this care intervention. (149)
3. Resident B prefers to be bathed by the private PSW. PSW E was on the bath team assigned to resident B on October 3, 2011 and was not aware of resident B's bath preference. When resident B refused to be bathed by PSW E, PSW E ignored resident B's response and proceeded to struggle with the resident B until resident B's private PSW intervened. PSW F who was assigned to resident B on Feb 29, 2012 was also not aware of resident B's bath preference to have the private PSW bathed him/her. (149)
4. PSW C assigned to resident G on November 28, 2011 on the day shift and PSW D assigned to resident G on November 28, 2011 on the evening shift both transferred resident G on their own. They were not aware of resident G's transfer requirements on the plan of care. Resident G required two staff for transferring. (149)
5. Resident A was assessed to be totally dependent for transfer and required two staff for transferring. PSW B reported to the Inspector that he/she transferred resident A alone to and from the shower chair on November 16, 2011. PSW B was not aware of resident A's transfer requirements. (149)
6. Residents' written plans of care are kept in PSW binder on all Resident Home Areas for convenient and immediate access by staff. Resident A's plan of care for ADL assistance was not in the PSW binder on March 1, 2012. PSWs who provided direct care to the resident A were not given convenient and immediate access to the current written plan of care. (149)

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

Ontario

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

Grounds / Motifs :

1. Resident F has responsive behaviour, which sometimes poses safety concerns for resident F and other residents on the unit. Resident F's plan of care did not include this behaviour and did not include the strategies put in place to deal with this behaviour. (149)
2. Resident E becomes physically aggressive when his hair is washed in the shower. The plan of care did not include this behaviour and the strategies identified to handle this behaviour. The plan of care did not provide clear directions to staff. (149)
3. Resident D has a responsive behaviour. The behaviour plan of care or ADL assistance plan of care did not include this behaviour and the strategies identified to handle this behaviour. The plan of care did not provide clear directions to staff. (149)
4. Resident C has been hypersensitive to odours since November 2010. The home developed strategies and interventions to help resident C cope with this problem. These strategies were not included in resident C's plan of care as of Feb 27, 2011. The plan of care did not provide clear directions to staff. (149)
5. Resident B's shower days are Mondays and Thursdays evenings. On resident B's plan of care, the bath days were Tuesdays and Thursday evenings. Resident B also prefers to be showered by the private PSW. The plan of care did not include this bath preference. The plan of care did not provide clear directions to staff. (149)
6. Resident G's plan of care for bathing did not include resident G's preferred bath time (days or evenings), bath days (days of the week) or bath type (shower or tub bath). The plan of care did not provide clear direction to staff. (149)
7. Preferred bath days on resident A's plan of care were Tuesdays and Fridays. Bath days on the bath list were Wednesdays and Saturdays. PSW A and PSW B reported to the inspector that resident A's bath days are Wednesdays and Saturdays. Resident A's plan of care did not provide clear directions to staff. (149)

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

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

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

and the

Director

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.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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 4th day of April, 2012

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

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

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