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

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
TORONTO, ON, M4V-2Y7
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55, avenue St. Clair Ouest, 8iém étage
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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
Mar 15, 16, 19, 20, 21, 22, Apr 2, 3, 4, 2012	2012_07649 _0008	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 Director of Care, Housekeeping Supervisor Registered staff, Personal Support Workers (PSWs), residents, resident's families, the Custodian, Housekeeping aides and Dietary aides.

During the course of the inspection, the inspector(s) observed resident care, walked through resident home areas, reviewed resident records and home's administrative records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Falls Prevention

Medication

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. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On December 30, 2011, Family member A witnessed a resident in the resident lounge who almost fell holding the broken arm of a chair. Family member A reported the incident to staff and the broken chair was removed. During the week of March 5, 2012, Family member A discovered two wobbly chairs in dining room A and informed the Nurse Manager. On March 14, 2012, the Custodian fixed 15 chairs that were wobbly or broken in dining room A. On March 15, 2012, the Inspector observed one wobbly chair in the dining room B, one chair with loose seat and two wobbly tables supported at the base with towels in the dining room C, one wobbly chair and one wobbly table supported at the base with cardboard in the dining room A, a green chair with a broken arm in a resident lounge. On March 19, 2012, the wall in resident A's room was observed to have several chipped paint [s.15(2)(c)].

2. The licensee did not ensure that the home, furnishings and equipment are kept clean and sanitary.

On March 15, 2012, the inspector observed a stain on the carpet outside a room and several carpet stains in the resident's lounge. The bathroom floor and the base of the toilets in three resident rooms were observed to be dirty. Staff reported to the inspector that resident's washroom were often not cleaned properly. On March 19, 2012 at 1200h, one housekeeping aide was observed leaving a room after cleaning the room. When the inspector entered the room, the floor was observed to be dirty. There were small pieces of papers and several dark stains on the floor [s.15(2)(a)].

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee did not ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On December 20, 2011 at 0800h, Tylenol 650mg (two tablets) was left on resident A's room on the side table to self-administer without the approval of the prescribing physician [r.131.(5)].

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 no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following subsections:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee did not ensure that every medication incident involving a resident is documented together with the immediate actions taken to assess and maintain the resident's health; reported to the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending to the resident and the pharmacy service provider; documented, reviewed and analyzed; corrective action taken as necessary; and written record of the analysis and corrective actions taken kept.

On November, 30 2011 in the evening, Aricept 5mg was discovered by Family member A in resident A's room on the floor. Aricept 5mg did not belong to resident A. Family member A gave the Aricept to the registered staff on the evening shift. The incident was not reported to the Director of Care, an incident report was not completed for this incident, the medication incident was not reviewed and analyzed, and a corrective action was not taken according to the Medication and Treatment Incident Form policy (PH-0112-00)[r.135.(1)(2)].

2. On December 20, 2011 in the evening, Tylenol 650mg (two tablets) was discovered by Family member B in resident A's room on the side table. It was documented in resident A's medication administration record that Tylenol 650 mg (two tablets) was administered that morning at 0800h. Family member A gave the Tylenol to the registered staff on the evening shift. The incident was not documented in resident A's record, an incident report was not completed for this incident, the medication incident was not reviewed and analyzed, and a corrective action was not taken according to the Medication and Treatment Incident Form policy (PH-0112-00)[r.135.(1)(2)].

3. On March 12, 2012 in the evening, Imovan 5mg was discovered by Family member A in resident A's room on the window sill. Family member A reported the incident and gave the medication to the registered staff on the evening shift. The incident was immediately reported to the Director of Care. An incident report was not completed for this incident, the medication incident was not reviewed and analyzed, and corrective action was not taken according to the Medication and Treatment Incident Form policy (PH-0112-00)[r.135.(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 every medication incident involving a resident is:
a. Documented together with the immediate actions taken to assess and maintain the resident's health;
b. Reported to the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending to the resident and the pharmacy service provider;
c. Documented, reviewed, analyzed and corrective action taken as necessary. Written record of the analysis and corrective actions taken kept, 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 _0008
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Mar 15, 16, 19, 20, 21, 22, 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. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

1. The licensee shall ensure that the home, furnishings and equipment are kept clean and sanitary.

2. The licensee shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Grounds / Motifs :

1. On March 15, 2012, the inspector observed a stain on the carpet outside a room and several carpet stains in the resident's lounge. The bathroom floor and the base of the toilets in three resident rooms were observed to be dirty. Staff reported to the inspector that resident's washroom were often not cleaned properly. On March 19, 2012 at 1200h, one housekeeping aide was observed leaving a room after cleaning the room. When the inspector entered the room, the floor was observed to be dirty. There were small pieces of papers and several dark stains on the floor. (149)
2. On December 30, 2011, Family member A witnessed a resident in the resident lounge who almost fell holding the broken arm of a chair. Family member A reported the incident to staff and the broken chair was removed. During the week of March 5, 2012, Family member A discovered two wobbly chairs in dining room A and informed the Nurse Manager. On March 14, 2012, the Custodian fixed 15 chairs that were wobbly or broken in dining room A. On March 15, 2012, the Inspector observed one wobbly chair in the dining room B, one chair with loose seat and two wobbly tables supported at the base with towels in the dining room C, one wobbly chair and one wobbly table supported at the base with cardboard in the dining room A, a green chair with a broken arm in a resident lounge. On March 19, 2012, the wall in resident A's room was observed to have several chipped paint. (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

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

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

Ministère 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 : B Bambo (149)

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

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