Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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
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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 20, 2015	2015_393606_0010	T-969-14	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
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

JANET GROUX (606)

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): July 23, 24, and July 27, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care(DOC), Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Care Assistants (PCA), Nurse Manager(NM), Physiotherapist(PT), and Substitute Decision Makers(SDM).
The inspector reviewed clinical health records,relevant home policies and procedures and conducted observations of resident care throughout the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Legendé 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of a critical incident dated in July 2014, reported Resident #001 was discovered on an identified date and time, lying on the floor. The assessment revealed resident had sustained possible injury, observed to be crying and complaining of pain. Resident was transferred to the hospital and diagnosed with a fracture and underwent surgery on the same day.

Review of Resident #001's written plan of care in place states that resident is high risk for falls and requires staff to monitor every hour (qhourly) for safety.

Interview with Personal Care Assistants (PCA) #100, and #101 revealed that Resident #001 is monitored often but not every hour.

Interview with the Director of Care (DOC) confirmed that the expectation of the home is for staff to follow the plan of care and confirmed staff did not. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care is documented.

Review of the home's policy entitled Falls Prevention and Management, identifies residents who engage in high risks behaviours such as attempting to get out of chair/bed on his/her own are to be checked on a regular basis.

Review of Resident #001's written plan of care states that resident is high risk for falls and directs staff to provide qhourly monitoring for safety and document on the qhourly monitoring records.

Review of Resident #001's qhourly monitoring records were not available.

Interview with PCA #100 revealed that he/she was not aware that it was a requirement to document and confirmed he/she did not complete one.

Interview with the DOC confirmed that staff are expected to document the safety checks on the qhourly monitoring records and confirmed that it was not completed. [s. 6. (9)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy is complied with.

Review of a critical incident dated in May 2014, reported Resident #002 was observed to be sweating and in discomfort while observed sitting in a lounge. The assessment completed revealed possible injury to the lower extremities, and the resident's facial expression indicated pain. Resident was transferred to the hospital the next day and diagnosed with a fracture requiring surgery.

Review of the home's policy entitled "Falls Prevention and Management", reveals that registered staff are to document the incident in detail in the progress notes.

Review of resident #002's progress notes revealed documentation of the incident was not entered in the progress notes on the above mentioned date.

Interview with RPN #103 revealed that he/she assumed that the registered staff who came to assist followed up on the incident and therefore he/she did not document in the progress notes.

Interview with the DOC confirmed that staff are expected to document all incidents in the progress notes and confirmed that staff did not follow policy. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee has failed to ensure that the records of the residents of the home are kept at the home.

Resident #002's progress notes were not available for review by the inspector from March, to May 2014.

Interview with the DOC revealed that the home's policy is to maintain all residents' records so they are accessible and available and confirmed that this was not done for resident #002. [s. 232.]

Issued on this 29th day of November, 2015

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

Original report signed by the inspector.