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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 25, 2016	2016_265526_0008	004939-16	Resident Quality Inspection

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

THERESA MCMILLAN (526), CATHIE ROBITAILLE (536), DARIA TRZOS (561), JESSICA PALADINO (586), NATASHA JONES (591)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 22, 23, 24, 25, 26, 29, March 1, 2, 3, 4, 8, 9, 10, 11, 14, and 15, 2016.

Follow up inspection 013194-15 was completed during this RQI.

The following Critical Incident inspections were completed simultaneously during this RQI:

004558-14 (Prevention of Abuse, Critical Incident Reporting)
005098-15 (Responsive Behaviours)
000964-15 (Falls Prevention, Plan of Care)
002696-16 (Duty to Protect, Continence Care)
018210-15 (Falls Prevention, Responsive Behaviours, Plan of Care)
006910-14 (Falls Prevention)

The following Complaint Inspections were completed during this RQI:
001915-15 (Skin and Wound, Continence Care, Communication and Response System, Plan of Care, Falls Prevention)
003705-16 (Duty to Protect, Continence Care, Skin and Wound)
008893-15 (Reporting and Complaints, Bedtime and Rest Routines, Pain Management, Reports and Critical Incidents, Restorative Care, Plans, End of Life Care, Residents' Bill of Rights)
004392-15 (Continence Care, Reporting and Complaints, Duty to Protect)
023055-15 (Falls Prevention, Pain Management, Continence Care)

The following Critical Incident Inspections were inspected by telephone inquiry:
Intakes 001777-15, 002869-14, 008335-14, 009775-14, 001224-15, 010078-15, 019232-15, 020186-15, 027340-15, 030214-15, 002321-16, 002195-14, and 034343-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Managers, Supervisor of Building Services, Nursing Clerk, Social Worker, Registered Nurses (RN's), Registered Practical Nurses (RPN's), Personal Care Attendants (PCA's), Registered Dietitian (RD), dietary staff, Behavioural Supports Ontario (BSO) staff, Resident Assessment Inventory (RAI) Coordinator, Family and Resident Council representatives, residents and family members.

During the course of the inspection, inspectors reviewed resident health records, investigative notes, complaints logs and files, maintenance logs and audits, infection control surveillance documentation and outbreak files, staff files, menus and dietary sheets, staff education records, programme evaluations, policies and procedures; toured the home; and observed dining services, residents and care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2015_382596_0003	561

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

According to resident #019's health record they were identified as being at high risk for choking and aspiration and had developed complications associated with this condition. Their plan of care reflected this however did not address risks associated with other residents feeding them.

During an annual care conference in early 2015, resident #019's Substitute Decision Maker (SDM) expressed concern that another resident was feeding resident #019 and that only Personal Care Attendants (PCA's) should feed them. During interview, resident #019's SDM complained to the Long Term Care Homes (LTC) Inspector that staff were allowing another resident to feed resident #019 and they were concerned about choking and associated complications. During interview, Registered Practical Nurse (RPN) #106 confirmed that the resident should have their food placed in front of them only when a staff person was available to assist them with feeding and that other residents should not be assisting with feeding.

During lunch dining service on February 25, 2016, LTC Inspectors observed staff placing food in front of resident #019 and leaving to attend to other residents. Another resident began feeding resident #019 while the resident was in a reclined position. Approximately half way through the serving, staff redirected the resident to their own meal, positioned resident #019 to an upright position and began to assist them with feeding.

During interview, RPN #106 and the Nurse Manager confirmed that the plan of care did not provide clear directions to staff regarding other residents feeding resident #019 to minimize the risk of resident #019 choking and/or aspirating during meal service.

B) Resident #019's health record indicated that the resident was at high risk for developing alteration in skin integrity and they required total care. The document the home referred to as their plan of care directed staff in interventions designed to decrease the resident's risk of developing altered skin integrity. The plan of care did not provide staff with direction on the application of a tilt to the resident's wheelchair.

During the course of this inspection, resident #019 was observed in the tilt position in their wheelchair. During interview, PCA #105 and RPN #106 could not state the plan of care regarding the use of the tilt. During interview, RPN #106 and the Nurse Manager #106 confirmed that resident #019's plan of care did not provide clear direction to staff regarding the use of the tilt chair as a means of reducing the risk of altered skin integrity. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Resident #041 was admitted to the home during a month in 2014. At that time, their admission assessments indicated that they were incontinent and were not toileted.

However, Behavioural Supports Ontario (BSO) admission notes and instructions to staff regarding the management of the resident’s responsive behaviours and agitation, directed them to toilet the resident if they were to get up at night. The document the home referred to as their care plan updated one month after admission, directed staff that resident #041 was not toileted for bowel or bladder elimination.

The resident had several falls in the first two months after admission. At this time, a Physiotherapy note indicated that the resident’s falls seemed related to continence and behaviour issues. The resident went on to have several more falls, and was hospitalized. During interview, Nurse Manager #125 confirmed that staff and others involved in the different aspects of care did not collaborate with each other in resident #041's continence assessment and management so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that care set out in the plan of care was provided as specified in the plan.

A) Resident #044's assessment conducted during a month in 2015 indicated that they required extensive assistance from one person to transfer and had total dependence on two staff for toileting. Their health record indicated that they had exhibited verbal and physical aggression toward co-residents. Staff confirmed that the resident's plan of care directed one staff to stay with the resident during toileting, and that two staff were required for transferring.

According to a Critical Incident System submission, resident #044 was left unattended in the washroom, exited and approached and allegedly hit resident #043. During interview, staff #115 who was working that day confirmed that the resident had been left unattended. The Nurse Manager #106 confirmed that care had not been provided to resident #044 as specified in their plan of care. (526)

B) The resident #050 was admitted to the home in 2015. The 24 hour Admission Care Plan indicated that the resident required supervision (oversight help) for ambulation and did not require any assistive devices. The Admission Assessment completed by the physiotherapy indicated that the resident was able to walk independently; no wheelchair was required.

The progress note written the day after admission indicated that the resident was placed in a wheelchair. The interview with the SDM stated that the resident was able to walk independently on admission and did not require a wheelchair. During interview, the Nurse Manager #125 confirmed that the staff should have followed the resident’s plan of care on admission. Based on the health care records, they could not confirm why the resident was placed in the wheelchair. The care set out in the plan of care was not provided to the resident as specified in the plan. (561) [s. 6. (7)]

4. The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A review of resident #037's most recent plan of care that was revised during this inspection, indicated that staff were to ensure the resident used a device to prevent injury. Observations of resident #037 throughout the inspection revealed they were not using the injury prevention device.

During interview, registered staff #138 stated that the resident used to wear hip protectors but no longer wore them as they refused. The staff member confirmed the resident’s plan of care had not been revised and updated when the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

5. The licensee failed to ensure that if a resident was being reassessed and the plan of care revised because care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care.

A) According to their health record, resident #051 was a high risk for falls and had a cognitive deficit. They fell on a specified day in 2015, sustained an injury that required treatment, and went on to have several falls. Directions for falls prevention after each fall were limited to monitoring and reminding resident to ask for help. The document the home referred to as resident #051's care plan that was in effect at the time of their falls, up to and including this inspection, had not changed and did not include interventions

staff stated were in effect. During interview Registered Nurse #119 stated that the resident needed repeated redirection and was not cognitively able to call for help or to use the call bell even though these were part of their falls prevention plan of care.

During interview, the Nurse Manger #102 who was responsible for the Falls Prevention programme in the home confirmed that the home did not use bed or chair alarms to reduce or mitigate falls in the home. They stated that an outside professional practice agency had advised the home's Falls Committee to promote the use of best practices in the home to include the use of bed and chair alarms as an evidenced informed strategy that was known to reduce or mitigate falls.

During interview, the Administrator verified that the home's "Falls Prevention and Management" policy RC-0518-21 last revised August 1, 2013, was in effect. The policy indicated the following: "NOTE: the use of bed/chair alarms are not approved as part of the falls prevention and management interventions. The interdisciplinary team performs comprehensive assessments to identify the causes and contributing factors for the resident's continued fall pattern. If families bring or insist that bed/chair alarms be incorporated into the care plan, refer the family to the Administrator". The Administrator stated that bed and chair alarms were not part of the arsenal of falls prevention strategies that the home had used to prevent falls.

The Nurse Manager confirmed that falls prevention strategies as outlined in resident #051's plan of care were not effective in decreasing their falls or potential for injury. They stated that different approaches had not been considered in the revision of the plan of care and that the use of the different approaches may have helped to prevent falls and injury for resident #051. (526)

B) Resident #041 was admitted to the home on a specified day in 2014. The resident sustained several unwitnessed falls. After the last of these falls, the resident was found lying on the floor beside their bed. The day after this fall their health condition deteriorated.

Prior to their last fall, the resident had sustained several falls (some with injury), and their Substitute Decision Maker (SDM) expressed concern about their safety due to recent falls and injury. Physiotherapy assessments completed at that time identified major contributors to the resident's falls and the SDM provided directions for staff regarding these contributors when the resident was admitted. However, the resident's post falls assessments and plan of care did not address these known contributors to their falls. In

addition, several post falls assessments were not conducted for falls prior to the fall that preceded a deterioration in the resident's health condition.

During interview Nurse Manager #125 suggested numerous strategies which may have been alternative falls and injury prevention strategies for resident #041. In addition, the Nurse Manager confirmed that the identified falls contributors and recommendations on admission by the SDM had not been integrated into the plan of care. Nurse Manager #125 confirmed that when the plan of care had not been effective in preventing resident #041's falls or mitigating injury, different approaches had not been considered in the revision of the plan of care. (526)

C) According to their health record, resident #048 was a high risk for falls, had a cognitive impairment. They sustained several falls since their admission to the home in 2014.They suffered an injury that required treatment in hospital after the last of these falls.

Post Fall Assessment Huddles conducted after these falls directed staff to remind the resident about falls prevention strategies. Health record documentation and interview with the Nurse Manager confirmed the resident was very forgetful and that reminding them to use the call bell or wear proper footwear was not appropriate or effective. They confirmed that different approaches had not been considered in the revision of the plan of care including more frequent monitoring and the use of devices such as hip protectors or a bed alarm and that the use of these may have helped prevent falls and injury for resident #048. (586)

D) According to their health record, resident #058 was a high risk for falls and had cognitive impairment. The resident fell and was found on the floor beside their bed on two occasions within a one month time period in 2015.

The Post Fall Assessment Huddle completed after these falls outlined falls prevention strategies that included resident #058 following instructions to prevent falls. Interview with the Nurse Manager confirmed that different approaches had not been considered in the revision of the plan of care including fall mats or a bed alarm. (586)

E) According to their health record, resident #012 was at risk for falls and had cognitive impairment. They had multiple falls during the past six months. Staff confirmed that most of the resident's falls occurred at night as they were not cognitively able to ask for staff assistance. Preventative measures were outlined in the resident's plan of care and did

not include the use of a bed alarm to alert staff if or when the resident would try to exit their bed.

The Nurse Manager did not recall discussions of resident #012 at the meetings and confirmed that different approaches had not been considered in the revision of the plan of care including the use of a bed alarm for resident #012. (591) [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident; to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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 failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) Resident #047 had limited movement, a respiratory condition and ongoing pain associated with their heath condition. The document the home referred to as their care

plan updated during a month in 2014, indicated that they required total assistance from two staff for hygiene and that two staff were to stay with them while being showered.

According to the home’s investigative notes and resident’s health records, Personal Care Attendant (PCA) #135 was assisted by PCA #136 to transfer resident #047 into a shower chair. After the transfer, PCA #136 left the shower room to attend to other residents. During the shower, the resident’s positioning shifted and they then began to complain of pain in an extremity. PCA #135 called PCA #136 and they transferred the resident to bed while the resident was moaning and stated that they had pain.

According to investigative notes, the PCAs did not inform the registered staff about the resident’s change in position while in the shower or that they had complained of pain afterward. Progress notes indicated that RPN #137 assessed the resident but was not aware of a possible injury to the resident.

The following day, the resident continued to received treatment for complaints of pain. The day after that the physician was contacted and resident was sent to hospital. They were diagnosed and treated in hospital for an injury to the extremity.

During interview, Nurse Manager #102 stated that PCA’s #135 and #136 did not provide care as outlined in resident #047's plan of care that directed them to shower the resident with two staff, and that this jeopardized the resident’s safety in the shower.

In addition, the Nurse Manager confirmed that PCA's #135 and #136 did not disclose what had happened in the shower room until the home began an investigation into the resident's injury. The Nurse Manager stated that this neglect prolonged the time between the injury and when the resident received treatment, care, services and assistance needed. The Nurse Manager confirmed that the PCA's neglect in not following the plan of care and their inaction by not informing registered staff afterward jeopardized resident #047’s health, safety and well-being.

B) Resident #041 was admitted to the home on a specified day in 2014. The resident sustained several unwitnessed falls. After the last of these falls, the resident was found lying on the floor beside their bed. The day after this fall their health condition deteriorated.

Progress notes indicated that staff were unable to reach the Physician or Nurse Practitioner on call and placed the note regarding the resident’s deterioration in the

doctor's book. The resident's symptoms further deteriorated; they were assessed by a physician several days after deterioration in their health for an unrelated issue, but not for the initial health changes after their fall. The resident was admitted to hospital and deceased.

During interview, the DOC confirmed that staff had neglected to ensure that resident #041 was reassessed when they demonstrated deterioration in their health after an unwitnessed fall which delayed the resident receiving treatment. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Personal Assistance Services Device (PASD) described in subsection (1) that was used to assist a resident with a routine activity of living was included in the residents' plan of care.

A) Resident #013 was observed by the Long Term Care Homes (LTC) Inspector in the program room sitting in a tilt wheelchair. Review of the most recent written plan of care did not include the use of the tilt wheelchair by this resident.

Interviews with registered staff #121 and PSW #129 confirmed the tilt wheel chair was used to help prevent the resident from falling. They also confirmed that the resident could not get out of the tilt wheel chair without assistance when the chair was in the tilt position. The registered staff confirmed that the written plan of care did not include the use of the tilt wheelchair.

B) Resident #012 was observed by the LTC Inspector sitting in the program room in a tilt wheelchair. Review of the most recent written plan of care did not include the use of the tilt wheelchair by this resident.

During interviews, registered staff #121 and PSW #129 confirmed that resident #013 required the use of the tilt wheel chair to help prevent the resident from falling. They confirmed that the resident could not get out of the tilt wheel chair without assistance when the chair was in the tilt position. The registered staff confirmed that the written plan of care did not include the use of the tilt wheelchair. [s. 33. (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 a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident requiring end-of-life care received care in a manner that met their needs.

A Nurse Practitioner progress note completed on a specified day in 2015, indicated that resident #050's Substitute Decision Maker (SDM) requested palliative care for the resident and that End of Life (EOL) medication management would be provided if needed. The SDM also requested that no oral medications be administered to the resident.

Review of the resident's health records indicated that that these directives were not carried out by the home on that day. The Long Term Care Homes (LTC) Inspector's interview with the SDM and the progress notes indicated that the SDM specifically asked for a specific palliative care medication to be given to resident #050 as part of their end of life care to start on the day the NP wrote the note.

The Medication Administration Record (MAR) and progress notes indicated that the medication was not started until a few days later. The MAR also indicated that an oral medication continued to be administered until three days later contrary to the SDM's expressed wishes. During interview Nurse Manager #125 confirmed that staff did not assess resident #050 for pain during their end of life care and that the resident did not receive appropriate pain management as requested by the SDM. The home failed to ensure that the resident requiring end of life care received care it in a manner that met their needs. [s. 42.]

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 resident receives end-of-life care when required in a manner that meets their needs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that: included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

Resident #042's RAI MDS assessment completed during a specified month in 2015, indicated that the resident was incontinent of both bowel and bladder. Review of the health record indicated that bladder continence assessment was completed once since admission, and bowel continence had not been assessed since admission in 2009. During interview, Registered Nurse # 134 stated that they were not aware that residents' continence should be assessed if there was a change.

Registered Practical Nurse #133 confirmed that resident #042's plan of care did not reflect the care provided. During interview, Nurse Manager #125 confirmed this and also that the resident's bowel continence had not been assessed since their admission in June 2009 and that bladder continence had been assessed only one time since admission. [s. 51. (2) (a)]

2. The licensee failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment.

According to resident #019's two most recent RAI MDS assessments, they were incontinent of bladder and bowel. The most recent continence assessment completed during the previous quarter directed staff to change the incontinent brief twice per shift and as needed. The document the home identified as the care plan completed three months later indicated that the resident was toileted with transferring instructions.

RPN #105 and the Nurse Manager #106 confirmed that the care plan had not been updated and did not reflect the continence care being provided to resident #019. [s. 51. (2) (b)]

3. The licensee failed to ensure that a resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Resident #042's RAI MDS assessment completed on a specified day in 2015, indicated that the resident was incontinent of both bowel and bladder during the 14 day assessment period. Even though the resident was incontinent they were also able to use the toilet if assisted to do so. Bowel continence assessment had not been completed.

On a specified day in 2016, resident #042 was noted to be incontinent of bowel into their brief. According to staff interviews and the home's investigative notes, staff assistance to resident #042 with toileting and incontinence was delayed several minutes.

Registered Nurse #119 and the DOC confirmed that resident #042 was unable to toilet independently and did not receive assistance from staff to manage and maintain their continence for several minutes on a specified day in 2016. [s. 51. (2) (c)]

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, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; (b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; and (c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #051 was a high risk for falls, was ambulatory, and had cognitive impairment. On a specified day in 2015, they fell, complained of pain in an extremity and were sent to hospital for treatment. The resident continued to fall several more times over the next three months. Progress notes indicated that they had received analgesia as needed.

The home's "Pain Assessment and Management" policy number RC=0518-01 revised on September 4, 2014 and October 1, 2015, directed staff to complete a pain assessment i) on admission; ii) on a newly prescribed pain medication daily for three days; iii) significant change in health status; and iv) when there was new or escalating signs of responsive behaviours – daily for three days; and iv) when a request for pain medication was administered for 48 hours consecutively.

A) Review of resident #051's available health record following the fall with injury requiring treatment, indicated that they were experiencing pain and received analgesia as needed. However, no further pain assessment was found according to the home's policy or when interventions were unsuccessful in the management of the resident's pain. During interview, the DOC could not verify that the resident had pain assessments completed when initial interventions were not successful in relieving the resident's pain.

B) According to progress notes the resident fell on a specified day in March, 2015. Later, the resident was observed by the LTC inspector to be standing but unable to walk. The resident's most recent pain assessment was conducted prior to their fall. They had received several doses of analgesia between this assessment and two days after their fall. During interview, RPN #121 and DOC confirmed that resident #051's pain had not been assessed using a clinically appropriate pain assessment instrument when their pain was not relieved by initial interventions. [s. 52. (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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Resident #044 returned to the home during a specified month in 2015, after receiving treatment for aggressive responsive behaviours. The resident had no incidents of aggression toward co-residents until they hit a co-resident, and then again when they allegedly hit co-resident #043. Review of resident #044's health record indicated that Behavioural Supports Ontario (BSO) staff were following the resident in relation to responsive behaviours. The document the home referred to as the care plan created when the resident returned to the home, did not include interventions that minimized the risk of altercations involving the resident hitting co-residents.

Nurse Manager #106 confirmed that the updated plan of care that directed staff regarding minimizing the risk of altercations and potentially harmful interactions between residents after the first incident since readmission was not part of the resident's plan of care. [s. 54. (b)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 101 (1).
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. O. Reg. 79/10, s. 101 (1).
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; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(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; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to 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

was investigated and resolved where possible, and a response that complied with paragraph 3 was provided within 10 business days; or for those complaints that could not be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint provided within 10 business days, and a response made to the person who made the complaint.

A) Review of resident #034's documented plan of care indicated they demonstrated socially inappropriate behaviour toward a co-resident. During Stage 1 of the RQI, resident #034 was observed saying inappropriate comments in the hallway to resident #037.

During the course of this inspection, resident #033 voiced concern regarding resident #034's behaviour in the dining room and that this upset and disturbed them. Resident #045 also voiced their concern about resident #034's disruption and inappropriate comments in the dining room.

Interview with registered staff #103 and PSW #101 confirmed that the resident was loud and inappropriate in the dining room on a regular basis. Personal Care Attendant (PCA) #101 confirmed that this was bothersome for other residents.

Resident #033 indicated they had reported this to Nurse Manager #102 on several occasions, and their concerns were documented, including the specific inappropriate comments made by resident #034; however, was not provided with any follow-up and did not see any resolution. Resident #045 indicated they also reported this to Nurse Manager #102 on one occasion; however, was told nothing could be done.

Interview with Nurse Manager #102 confirmed they were aware of resident #034's disruptive behaviour in the dining room at times and confirmed it could be disruptive to some residents during meals. They confirmed this issue was still ongoing and had not been investigated or resolved. (586)

B) Resident #056 was admitted to the home on a specified day in 2015. During interview, their SDM stated that they gave a letter of complaint to the Nurse Manager #125 regarding care provided to resident #056. The SDM stated that they had not received a reply to their letter of complaint until more than one month after giving the letter to the Nurse Manager. During interview, the DOC confirmed that an acknowledgement of resident #056's SDM's letter of complaint was not provided within 10 days as specified by legislative requirements. (526)

C) According to interview with the resident #019's family member, two pieces of resident #019's clothing became damaged while being laundered in 2015. The resident's family member complained to the Administrator and the family member reported to the LTC Inspector that the issue was only partially resolved, and they had not received any further information about the status of the clothing repair or replacement.

During interview with the LTC Inspector, the DOC stated that the clothing could not be repaired and confirmed that they had not provided a follow up response to resident #019's family member within 10 days. [s. 101. (1)]

2. The licensee failed to ensure that a documented record of a verbal complaint that was not resolved within 24 hours was kept in the home that included the following:
(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 by the complainant.

According to interview with resident #019's family member, two pieces of resident #019's clothing became damaged beyond repair while being laundered in 2015. The resident's family member complained to the Administrator and the family member reported to the LTC Inspector that the issue was only partially resolved months later, and they had not received any further information about the status of the clothing repair or replacement.

During interview, the DOC confirmed that the home had not retained a documented record of the home's management or responses to the verbal complaints made by resident #019's family member regarding clothing that was damaged in the laundry. [s. 101. (2)]

3. The licensee failed to ensure that (a) the documented record (of complaints received) was reviewed and analyzed for trends, at least quarterly; (b) the results of the review and analysis were taken into account in determining what improvements were required in the home, and (c) a written record was kept of each review and of the improvements made in response.

During the course of this inspection, LTC Inspectors reviewed health records and the home's complaints logs. During interviews, Nurse Managers #102 and #106, and the DOC stated that complaints were informally documented in their personal notes and files and were not consistently compiled in a complaints record that would contribute to a quarterly or annual analysis. The DOC confirmed that the home conducted informal, verbal and periodic reviews and analysis of complaints. The DOC was unable to provide documented records of the complaints review and analysis, or of the improvements made in response to the analysis. [s. 101. (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 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;

To 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; and

To ensure that, (a) the documented record is reviewed and analyzed for trends at least quarterly; (b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and (c) a written record is kept of each review and of the improvements made in response, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident, subject to subsection (3.1), an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

On a specified day in 2015, resident #051 fell and sustained an injury to an extremity that required treatment. They returned to the home the same day and required pain management. Review of the Critical Incident System indicated that a Critical Incident (CIS) had not been submitted to the Director. During interview, the Nurse Manager #125 confirmed that the Director had not been informed when resident #051 sustained an injury that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital. [s. 107. (3)]

2. The licensee has failed to ensure that amendments were made to the Critical Incident System (CIS's) submitted.

A review of 19 Critical Incident System (CIS) Notifications to the Director between October 2013 and January 2016, was completed with the home on February 24 and 25, 2016. It was identified that most of those CIS's in which amendments were requested were not responded to by the home. This was confirmed with the Nurse Managers; Director of Care, and Administrator. [s. 107. (4) 4.]

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 a licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence, to be implemented voluntarily.

WN #10: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's "Criteria for the use of Restraining Device - Restraints and PASD with Restraining Effects" policy number RC-0518-06, last revised August 1, 2010, and "Decision Tree for Restraining Devices"policy # number RC-0518-10, last revised August 1, 2010, indicated that PASD's with restraining effects may be utilized only with consent, a medical order for PASD use, documentation of hourly safety and comfort checks, release and repositioning, and note on the care plan.

Resident #013 was observed sitting in the program room in a tilt wheelchair. During interviews, registered staff #121 and PSW #129 confirmed that resident #013 required the use of the tilt wheelchair to help prevent the resident from falling. The staff further confirmed that the resident could not get out of the tilt wheel chair without assistance when the chair was in the tilt position.

Review of the most recent written plan of care did not include the use of the tilt wheelchair by this resident. Review of the medical chart did not include consent for PASD use, medical order for PASD use, or hourly checks for safety and comfort during tilt wheel chair use as required by the home's policy.

Interview with the Nurse Manager #125 confirmed they did not consider the tilt wheelchairs a PASD with restraining effects and did not obtain consent or medical orders for their use according to their policy. [s. 8. (1) (b)]

WN #11: 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:

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's policy called "Zero Tolerance of Abuse and Neglect", policy number RC-0305-00, last reviewed October 1, 2010, directed staff to "report to the Ministry of Health and Long-Term Care (MOHLTC) every suspected or confirmed incident of abuse and neglect and notify the MOHLTC immediately that an alleged, suspected or witnessed incident of abuse or neglect has become known and an investigation is underway".

Progress notes and interview with Nurse Manager #102 indicated that a family member brought up a concern of alleged verbal abuse from staff towards resident #049. The review of the Critical Incident System (CIS) indicated that the home did not report the allegation of verbal abuse towards resident #049 to the MOHLTC. The interview with the Nurse Manager confirmed that the home had not submitted a Critical Incident report to MOHLTC and was not compliant with the home's Zero Tolerance of Abuse and Neglect policy or with legislative requirements. [s. 20. (1)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any written complaints that were received concerning the care of a resident or the operation of the home were forwarded to the Director.

Resident #056's substitute decision maker (SDM) provided Long Term Care Homes (LTC) Inspectors with a letter of complaint that was given to Nurse Manager #125 regarding the care of their family member. During interview, the Nurse Manger confirmed that the written letter of complaint had not been forwarded to the Director according to legislative requirements. [s. 22. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's special treatments and interventions.

Resident #001 was observed to have limitations of movement of all extremities. During review of the resident's most recent written plan of care revealed that it did not include that the resident had these limitations. The most recent RAI MDS assessment identified that the resident had limitations to movement but that they did not receive treatment. [s. 26. (3) 18.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a multi disciplinary care conference was conducted to discuss the plan of care and any matters of importance to the resident or their SDM within six weeks of the admission of the resident and that the resident's SDM was invited to participate in these care conferences.

Resident #056 was admitted to the home on a specified day in 2015. During interview, their substitute decision maker (SDM) stated that they frequently visited the home since the resident's admission and complained to the Long Term Care Homes (LTC) Inspector that the six week care conference had not been held. They stated that they had care issues that they wanted to discuss with the home regarding the care provided to resident #056.

During interview, the DOC stated that the home's protocol for setting up care conferences was that a letter was sent to the SDM's home address. Resident #056's SDM stated never receiving the letter and wondered why a staff didn't inform them of the meeting since they were in the home almost every day. The DOC confirmed that the SDM had not received an invitation to participate in resident #056's care conference and that the care conference had not been held within six weeks of the resident's admission to the home. [s. 27. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that assistive aids, or positioning aids used for the personal support services program were appropriate for the resident based on the resident's condition.

Resident #001 was observed to have limitation of movement of all limbs. Personal Care Attendant (PCA) #139 was observed during care to provide a treatment relating to this limitation.

A review of the residents health record indicated no documentation of an assessment by an Occupational Therapist (OT) or Physiotherapist (PT), nor was a nursing referral completed to rehabilitation services related to the residents limitations.

An interview with the Physiotherapist (PT) and Rehab Assistant (RA) confirmed that resident #001was not a part of the rehab program. The Occupational Therapist (OT) confirmed that a referral from nursing was not received and a needs assessment for the resident had not been completed. [s. 30. (1) 2.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the advice of the Residents' and Family Councils were obtained in developing and carrying out the satisfaction survey, and in acting on its results.

During interview, the Residents' Council President, a Family Council member, and the Administrator confirmed that the home did not seek the Councils' advice in the development and carrying out, and acting on the results of the 2015 satisfaction survey. [s. 85. (3)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair.

On March 1, 2016, during a tour of 11 third floor resident washrooms, five raised toilet seats with handles were observed to have degraded, cracked, and sloughing foam protectors on the handles. During interview, registered staff #108 stated that direct care staff were to inform the registered staff of maintenance issues in the home. During interview, the DOC stated that an audit of resident washrooms had not been conducted in over one year, and the poorly maintained raised toilet seats had not been identified. They stated that direct care staff also should have informed registered staff of maintenance issues as they arose. The DOC confirmed that procedures had not been implemented to ensure that resident raised toilet seats were kept in good repair. [s. 90. (2) (b)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On March 03, 2016, LTC Inspector observed the emergency drug supply located in a cabinet above the sink in home area 3North's medication room. The emergency drug supply that the home refered to as the 'off hours medication supply' contained controlled substances and other medications sitting in white plastic baskets on the shelf. The door to the cabinet was left unlocked on March 3, 2016.

During interview, the DOC confirmed that the controlled substances were not stored as required and should have been stored in a separate double locked cabinet in the locked medication room. [s. 129. (1) (b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept relating to each evaluation under clause (d) of r. 229(2) that included the date of the Infection Prevention and Control (IPAC) Program evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During interview, Nurse Manager #125 responsible for the home's IPAC Program stated that infections in the home were reviewed daily and informally discussed monthly, but no monthly report was created about this discussion. This was confirmed on review of the minutes for the IPAC monthly meetings which did not include a review or analysis of trends of the infections in the home. In addition, during review, the home's annual 2015 IPAC evaluation did not include an analysis of ongoing surveillance in the home, a summary of changes made in response to analysis of infection trends and the date that changes had been implemented. The Nurse Manager and DOC confirmed that these details were missing from the home's annual 2015 IPAC evaluation. [s. 229. (2) (e)]

2. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

The LTC Inspector observed a medication pass on March 3, 2016, on home area 3North between the hours of 1145 and 1245. The RPN #117 administered eye drops to resident #053 and no hand hygiene was performed by the RPN prior to or after the eye drop administration. The RPN then checked blood sugar for resident #054. No hand hygiene was performed before or after the procedure. After lunch the RPN brought back the medication cart to the medication room, opened a new bottle of eye drops to be administered to resident #055 and preceded to resident's room and administered eye drops. No hand hygiene was performed before or after administration of the eye drops. The RPN confirmed that the hand hygiene should have been performed before and after administration of the eye drops. [s. 229. (4)]

Issued on this 9th day of May, 2016

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

Original report signed by the inspector.

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	THERESA MCMILLAN (526), CATHIE ROBITAILLE (536), DARIA TRZOS (561), JESSICA PALADINO (586), NATASHA JONES (591)
Inspection No. / No de l'inspection :	2016_265526_0008
Log No. / Registre no:	004939-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 25, 2016
Licensee / Titulaire de permis :	City of Toronto 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 :	Judy Watson

To City of Toronto, 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall do the following:

1. Review, integrate and implement current evidence based and leading practices for falls prevention into the home's Falls Prevention and Management Program to include the use of equipment, supplies, devices and assistive aids such as bed and chair alarms and according to the home's consultations and recommendations from professional practice organizations.

2. Identify root causes for each fall by fully completing the Post Fall Huddle after every fall according to the home's "Falls Prevention and Management" policy RC-0518-21. Additional Information that could be considered in this assessment include falls frequency, time of day, circumstances and location of each fall in this analysis.

3. Use the root causes identified to plan realistic falls prevention strategies that take into consideration a resident's cognitive and physical conditions and limitations. Include the management of related care areas such as behaviour management, and continence in falls prevention strategies.

4. Include these falls prevention strategies in the resident's plan of care/care plan so that direct care staff have easy access and clear direction regarding interventions to be implemented for each resident.

5. Implement and document the implementation of falls prevention strategies.

6. When the falls prevention plan of care is being revised because care set out in the plan has not been effective, different approaches are to be considered in the revision of the plan of care for each resident who has fallen.

7. Train all direct care staff in the home's Falls Prevention and Management Programme with specific emphasis on falls prevention, identification of root causes, identification of realistic falls prevention strategies based on the resident's cognitive and physical condition, inclusion of falls prevention strategies in the resident's plan of care, implementation and documentation of the strategies, evaluation of the effectiveness of falls prevention strategies, and the inclusion of different approaches if the plan of care has not been effective in preventing falls and/or injury associated with falls.

8. Evaluate and update the home's Falls Prevention and Management Program in accordance with evidence-based practices at least annually.

Grounds / Motifs :

1. Judgment Matrix:
Noncompliance Severity: Actual harm/risk
Noncompliance Scope: Pattern
Compliance History: Previously issued as a WN on December 9, 2013.

2. The licensee failed to ensure that if a resident was being reassessed and the plan of care revised because care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care.

A) According to their health record, resident #051 was a high risk for falls and had a cognitive deficit. They fell on a specified day in 2015, sustained an injury that required treatment, and went on to have several falls. Directions for falls prevention after each fall were limited to monitoring and reminding resident to ask for help. The document the home referred to as resident #051's care plan that was in effect at the time of their falls, up to and including this inspection, had not changed and did not include interventions staff stated were in effect. During interview Registered Nurse #119 stated that the resident needed repeated redirection and was not cognitively able to call for help or to use the call bell even though these were part of their falls prevention plan of care.

During interview, the Nurse Manger #102 who was responsible for the Falls Prevention programme in the home confirmed that the home did not use bed or chair alarms to reduce or mitigate falls in the home. They stated that an outside professional practice agency had advised the home's Falls Committee to promote the use of best practices in the home to include the use of bed and chair alarms as an evidenced informed strategy that was known to reduce or mitigate falls.

During interview, the Administrator verified that the home's "Falls Prevention and Management" policy RC-0518-21 last revised August 1, 2013, was in effect. The policy indicated the following: "NOTE: the use of bed/chair alarms are not approved as part of the falls prevention and management interventions. The interdisciplinary team performs comprehensive assessments to identify the causes and contributing factors for the resident's continued fall pattern. If families bring or insist that bed/chair alarms be incorporated into the care plan, refer the family to the Administrator". The Administrator stated that bed and chair alarms were not part of the arsenal of falls prevention strategies that the home had used to prevent falls.

The Nurse Manager confirmed that falls prevention strategies as outlined in resident #051's plan of care were not effective in decreasing their falls or potential for injury. They stated that different approaches had not been considered in the revision of the plan of care and that the use of the different approaches may have helped to prevent falls and injury for resident #051. (526)

B) Resident #041 was admitted to the home on a specified day in 2014. The resident sustained several unwitnessed falls. After the last of these falls, the resident was found lying on the floor beside their bed. The day after this fall their health condition deteriorated.

Prior to their last fall, the resident had sustained several falls (some with injury), and their Substitute Decision Maker (SDM) expressed concern about their safety due to recent falls and injury. Physiotherapy assessments completed at that time identified major contributors to the resident's falls and the SDM provided directions for staff regarding these contributors when the resident was admitted. However, the resident's post falls assessments and plan of care did not address these known contributors to their falls. In addition, several post falls assessments were not conducted for falls prior to the fall that preceded a

deterioration in the resident's health condition.

During interview Nurse Manager #125 suggested numerous strategies which may have been alternative falls and injury prevention strategies for resident #041. In addition, the Nurse Manager confirmed that the identified falls contributors and recommendations on admission by the SDM had not been integrated into the plan of care. Nurse Manager #125 confirmed that when the plan of care had not been effective in preventing resident #041's falls or mitigating injury, different approaches had not been considered in the revision of the plan of care. (526)

C) According to their health record, resident #048 was a high risk for falls, had a cognitive impairment. They sustained several falls since their admission to the home in 2014.They suffered an injury that required treatment in hospital after the last of these falls.

Post Fall Assessment Huddles conducted after these falls directed staff to remind the resident about falls prevention strategies. Health record documentation and interview with the Nurse Manager confirmed the resident was very forgetful and that reminding them to use the call bell or wear proper footwear was not appropriate or effective. They confirmed that different approaches had not been considered in the revision of the plan of care including more frequent monitoring and the use of devices such as hip protectors or a bed alarm and that the use of these may have helped prevent falls and injury for resident #048. (586)

D) According to their health record, resident #058 was a high risk for falls and had cognitive impairment. The resident fell and was found on the floor beside their bed on two occasions within a one month time period in 2015.

The Post Fall Assessment Huddle completed after these falls outlined falls prevention strategies that included resident #058 following instructions to prevent falls. Interview with the Nurse Manager confirmed that different approaches had not been considered in the revision of the plan of care including fall mats or a bed alarm. (586)

E) According to their health record, resident #012 was at risk for falls and had cognitive impairment. They had multiple falls during the past six months. Staff confirmed that most of the resident's falls occurred at night as they were not

cognitively able to ask for staff assistance. Preventative measures were outlined in the resident's plan of care and did not include the use of a bed alarm to alert staff if or when the resident would try to exit their bed.

The Nurse Manager did not recall discussions of resident #012 at the meetings and confirmed that different approaches had not been considered in the revision of the plan of care including the use of a bed alarm for resident #012. (591) (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

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. 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 do the following:

1. Review with all staff, the home's ""Zero Tolerance of Abuse and Neglect", policy number RC-0305-00 specifically regarding staff's responsibility to provide care according to the plan of care, to inform registered staff of incidents involving residents and that residents will be assessed and reassessed by a physician or nurse practitioner when their care needs change so that they receive treatment as needed.

2. Staff will follow residents' plans of care regarding the number of staff required to provide personal care and hygiene to residents.

3. Staff will inform registered staff of incidents involving improper transferring and positioning or where residents' positioning (may) have caused injury and pain.

4. Staff will make contact with the appropriate health providers, including on-call physicians and nurse practitioners, to inform them that a resident's care needs had changed so that the resident is assessed in a timely manner according to the home's expectations.

Grounds / Motifs :

1. Judgment Matrix:
Noncompliance Severity: Actual harm/risk
Noncompliance Scope: Isolated
Compliance History: Previously issued as a VPC on March 6, 2015.

2. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) Resident #047 had limited movement, a respiratory condition and ongoing pain associated with their heath condition. The document the home referred to as their care plan updated during a month in 2014, indicated that they required total assistance from two staff for hygiene and that two staff were to stay with them while being showered.

According to the home's investigative notes and resident's health records, Personal Care Attendant (PCA) #135 was assisted by PCA #136 to transfer resident #047 into a shower chair. After the transfer, PCA #136 left the shower room to attend to other residents. During the shower, the resident's positioning shifted and they then began to complain of pain in an extremity. PCA #135 called PCA #136 and they transferred the resident to bed while the resident was moaning and stated that they had pain.

According to investigative notes, the PCAs did not inform the registered staff about the resident's change in position while in the shower or that they had complained of pain afterward. Progress notes indicated that RPN #137 assessed the resident but was not aware of a possible injury to the resident.

The following day, the resident continued to received treatment for complaints of pain. The day after that the physician was contacted and resident was sent to hospital. They were diagnosed and treated in hospital for an injury to the extremity.

During interview, Nurse Manager #102 stated that PCA's #135 and #136 did not provide care as outlined in resident #047's plan of care that directed them to shower the resident with two staff, and that this jeopardized the resident's safety in the shower.

In addition, the Nurse Manager confirmed that PCA's #135 and #136 did not disclose what had happened in the shower room until the home began an investigation into the resident's injury. The Nurse Manager stated that this neglect prolonged the time between the injury and when the resident received treatment, care, services and assistance needed. The Nurse Manager confirmed that the PCA's neglect in not following the plan of care and their inaction by not informing registered staff afterward jeopardized resident #047's health, safety

and well-being.

B) Resident #041 was admitted to the home on a specified day in 2014. The resident sustained several unwitnessed falls. After the last of these falls, the resident was found lying on the floor beside their bed. The day after this fall their health condition deteriorated.

Progress notes indicated that staff were unable to reach the Physician or Nurse Practitioner on call and placed the note regarding the resident's deterioration in the doctor's book. The resident's symptoms further deteriorated; they were assessed by a physician several days after deterioration in their health for an unrelated issue, but not for the initial health changes after their fall. The resident was admitted to hospital and deceased.

During interview, the DOC confirmed that staff had neglected to ensure that resident #041 was reassessed when they demonstrated deterioration in their health after an unwitnessed fall which delayed the resident receiving treatment. (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 25th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Theresa McMillan

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