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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 14, 2018	2017_685648_0018	028731-17	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

JOVAIRIA AWAN (648), SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 14, 15, 19, 20, 22, 27, 28, 29, 2017, January 2, 3, 4, and January 10, 2018.

The following intakes were inspected concurrently with the Resident Quality Inspection:
Critical Incident Systems (CIS):
Log #008490-17 (CIS #M612-000016-17) related to falls
Log #012308-17 (CIS #M612-000013-17) related to falls

Complaint:
Log #025691-17 related to resident charges and recreation and social activities

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), RAI Coordinator, Nursing Manger (NM), Behavioural Supports Ontario (BSO) Lead, Social Worker, Recreational Assistant (RA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Residents, Substitute Decision Makers (SDM), and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Recreation and Social Activities
Residents' Council
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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 when a resident is reassessed and the plan of care is reviewed and revised because care set out in the plan had not been effective, different approaches are considered in the revision of the plan of care.

Resident #002 was identified in Critical Incident Report (CIS) submitted to the MOHTLC on an identified date, indicating that the resident had an unwitnessed fall in their home area and sustained an injury. The resident was found seated in their home area and reported they had fallen.

Review of the homes "Falls Prevention and Management" policy (RC 0518-21, October 1, 2016) directed appropriate staff to formulate strategies based on assessment results for residents identified as being at low and high risk to safeguard the resident against future falls considering contributing factors such as continence needs and cognition. The policy identified the following risk factor and recommended strategy to address it in Appendix D:
- FALL RISK FACTOR: Resident engages in high risk behaviour. Attempts to get out of chair/bed to toilet on his/her own.
- STRATEGIES: Offer day time naps to decrease restlessness Check on a regular basis, offer toileting at fixed times throughout the waking/sleeping hours.

Observations of resident #002 conducted at the time of the inspection identified they were self-ambulatory with a walker.

Review of resident #002's written plan of care in place prior to the identified fall in the CIS, indicated that resident #002 was at risk of falls due to unsteady gait, past falls, related difficulty judging distance, and an identified medical condition. Interventions to address resident #002's falls risk included that the night staff to check resident #002

every two hours, and directed staff to approach the resident for toileting assistance.

Review of resident #002's clinical records indicated that the resident fell on the identified date (as specified in the CIS) during the night shift in their home area. The progress notes reviewed identified that resident #002 was found by the personal care assistant seated. Resident #002 sustained an identified injury. The resident stated that they also hurt a limb and that it was very painful. Resident #002 was subsequently assessed and sent to hospital for further assessment.

A subsequent fall was identified on a later date, in which a progress notes documented the resident was attempting to self-toilet and had fallen. Resident #002 was found by a personal care assistant in sitting position on the floor in a resident area. The progress note identified resident #002 reported they wanted to use the washroom. The progress note documented that the care plan was revised and that the interventions were current and applicable. No injuries were noted at this fall.

Review of residents Post Fall Assessment Huddle for both identified falls, indicated resident 002's known history of falls. The assessment further identified the following contributing factors to the fall:
Toileting – No established toilet routine or toilet routine not followed
Transferring – Improper transfer method (resident attempts to transfer without assistance or care not followed by staff).

The written plan of care was reviewed and revised following the first fall and identified resident #002's falls history including the fall noted in the CIS. Record review did not identify any further revisions following this fall, of resident #002's written plan of care up until and during the time of this inspection for interventions to mitigate their risk of falls except that staff were directed to offer an identified intervention. Resident #002's continence care interventions in the plan of care identified that they would attempt to self toilet, and staff were required to take them to the toilet upon waking, after meals, and at HS. Resident #002 was identified to require staff assistance for transfer and continence care.

Interview with PSW #106 identified that resident #002 required supervision when ambulating and had impaired cognition. PSW #106 reported resident #002 was unsteady on their feet and required a walker for mobility. PSW #106 identified resident did not use the call bell and was known to attempt to self-toilet without staff assistance.

RN #111 and RPN #112 reported their awareness of resident #002 and their known falls risk which included the resident attempting to self-toilet. RN #111 identified resident was to be toileted by staff during the day shift after meals and before bed during evenings. RN #111 and RPN #112 identified resident #002 would be offered toileting assistance twice during night shift care rounds and whenever staff would check the resident during routine monitoring. RN #111 and RPN #112 identified they had responded to resident #002's fall on the identified date noted in the CIS. Both staff identified that resident #002 was found during regular rounds by staff, with an injury, in their home area, and that the resident reported they had attempted to self-toileted. RN #111 and RPN #112 stated resident #002 sustained the fall as a result of attempting to self-toilet. RN #111 and RPN #112 were unable to identify whether resident #002's plan of care was revised to consider different approaches to prevent falls, following review and post-fall assessment of their falls sustained on the identified fall or the subsequent fall on the later date.

Resident #002's post fall huddle assessments as noted above were reviewed with the homes RAI coordinator. The RAI coordinator was unable to demonstrate what interventions, if any, the home had considered to address these risk factors for resident #002 following their fall on the identified date and the subsequent later date, in order to prevent future falls.

Interview with the homes administrator identified that when a resident in the home had a witnessed or unwitnessed fall, the interdisciplinary care team was to review current interventions, evaluate them, and make recommendations such as changes to interventions which would mitigate a residents falls risk. Resident #002's fall history and clinical records were reviewed with the homes Administrator. The Administrator acknowledged that the home did not consider alternative approaches or interventions to address the resident #002's known history to self toilet in order to manage their falls risk and that their plan of care had not been reviewed and that different approaches had not been considered following the post-fall assessment. [s. 6. (11) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

O. Reg. 79/10, s. 49 (2). Requires every licensee of a long-term care home to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #012 was identified in stage 1 of the RQI for falls.

Review of the homes Falls Prevention and Management policy (RC-0518-21, October 1, 2016) identified that the Nurse Manager would conduct a Post Fall Assessment Huddle meeting with the interdisciplinary care team present on the unit at the time of the fall. Identify root causes for the fall and prevention strategies for future fall and injury prevention. Document the meeting on the Post Fall Assessment Huddle Form and place in chronological order in the section of Health Care Record in Progress Notes.

Review of resident #012's records identified they had a fall on an identified date, witnessed by their spouse and a staff member, when attempting to get up from their wheelchair. Resident #012's physical chart identified the following assessments and documentation was completed for this witnessed fall:
Incident Report
Head to Toe Skin Assessment
Morse Fall Scale.
A Post Fall Huddle was not identified in resident #012's chart during the inspection.

Interview with RPN #113 reported that a resident with a fall would have a Post Fall Huddle, Incident Report, Head Injury Routine, Vital Signs, Head to Toe Skin Assessment, and referrals to Occupational and Physical therapy completed following a fall. Resident #012's clinical records for the fall on the identified date, were reviewed with RPN #113 during the interview. RPN #113 was unable to identify or demonstrate that a Post Fall Huddle had been completed for the resident.

Interview with the homes DOC confirmed resident #012 did not receive a Post Fall Huddle following the witnessed fall on the identified date, acknowledged the homes process had not been followed. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that no payment be accepted from or on behalf of a resident for anything the licensee is prohibited from charging under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf.

The MOHLTC received a complaint related to resident charges regarding recreational and social activities. The complainant, identified as resident #013's Substitute Decisions Maker SDM, reported that they had to pay an additional personal cost, for resident #013 to attend activities. The complainant identified that the home did not facilitate resident #013's attendance to activities in the home. The complainant indicated that resident #013 enjoyed attending music programs and activities in the home.

Review of the homes long stay 'Admission Agreement' (December 2014) of the City of Toronto Long Term Care Homes and Services operating Wesburn Manor Long Term Care home outlined the following within the homes accommodation fees guidelines:

1.9 The home shall provide the goods and services included in basic or preferred accommodation listed on Schedule B.

Review of Schedule B: Goods & Services provided at no additional cost outlined the following
The following standard products, care, programs and services are paid for by the Ministry funding and resident accommodation fees, and are provided by the home at no additional cost to the resident:
- Resident care and support programs that are based on assessments of the resident

and the resident’s needs and preferences. The plan of care and programs include medical, nursing, personal support, nutritional, dietary, recreational, social restorative, religious and spiritual care.
- An organized program of recreational and social activities which meet the interests of the residents and the related supplies and equipment.

Review of resident #013’s written plan of care identified the resident with behaviours and directed staff to provide diversional activities and encourage involvement in activities. The written plan of care also identified that resident enjoyed music.

Review of resident #013's progress notes identified an annual conference in which the residents' SDM expressed concerns as to whether resident #013 would continue to attend activities and programs in the home following a transfer to another unit. Subsequent progress notes, identified resident #013's SDM employed a private companion to accompany resident #013 to activities and programs.

Interview with RA #101 reported that resident #013 enjoyed attending music and dancing programs. RA #101 indicated that resident had identified responsive behaviours but was unable to demonstrate if one to one or supervision was offered to resident #013 in order to attend activities.

Interview with SW #102 reported that resident #013 enjoyed music programs and that it was of benefit to the resident to attend. SW #102 reiterated that resident #013 required one on one supervision in order to attend activities. SW #102 revealed resident #013's SDM employed a private companion to accompany resident #013 to activity programs in the home. SW #102 identified that residents such as resident #013, who required additional staff in order to attend programs and activities in the home, were not required to pay at extra cost. SW #102 confirmed the homes process as outline in the admission agreement, was not implemented in this case.

Interview the homes administrator revealed that residents with expressed and assessed preferences to attend programs and activities in the home were to be offered facilitated assistance to attend accordingly. The administrator acknowledged the homes process to provide resident care and support programs including recreational activities access to resident #013 at no additional cost was not followed. [s. 91. (4)]

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Issued on this 23rd day of February, 2018

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

Original report signed by the inspector.