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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 1, 2019	2019_659189_0007	008030-19, 011355-19	Complaint

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

NICOLE RANGER (189), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 15, 16, 17, 18, 19, 22, 23, 2019.

The following intakes were inspected:
Log # 011355-19 related to continence care and personal support services
Log # 008030-19 related to admission and discharge

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Nurse Manager of Operations Behavioural Support Ontario (BSO) nurse, BSO PSW, Environmental Supervisor, Physician, Chief Executive Officer (CEO) of Operations City of Toronto, Local Health Integration Network (LHIN) Discharge Planner, Care Coordinator Central West LHIN, Care Coordinator Central East LHIN, Dietary Aide, registered staff, personal support workers, residents and family members.

During the course of the inspection the inspectors observed staff to resident interactions, conducted observations of the residents, reviewed residents' health records, reviewed home's investigation notes, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
3 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	Légende 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every resident has the right not to be neglected by staff.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint intake #011355-19 related to continence care. According to the complainant, resident #001 was found on three occasions to be incontinent and wearing two incontinent products.

Record review and staff interview revealed that on an identified date, the family of resident #001 arrived on the unit and found the resident to be incontinent and wearing an heavily soiled incontinent product with another incontinent product placed on top. The family member informed the nursing staff and spoke with RN #101 about the incident. Interview with RN #101 revealed that they observed resident #001 to be soiled and spoke with the assigned PSW #106 and requested that the PSW provide the resident with a shower. RN #101 reported that PSW #106 refused to assist the resident with a shower and the PSW left the unit. RN #101 reported that they went to assist the resident with the shower, and while providing care to the resident, RN #101 confirmed that the resident was wearing two incontinent products. RN #101 reported that it did not appear that the resident's incontinent product was changed.

Interview with the Director of Care (DOC) confirmed that an investigation into the incident was started. The DOC confirmed that the actions of PSW #106 did not respect resident #001's rights.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: Every resident has the right not to be neglected by the licensee or staff, to be implemented voluntarily.

WN #2: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker has been provided the opportunity to participate fully in the development and implementation of the plan of care.

The MOHLTC received a complaint intake #011355-19 related to continence care and personal support services. According to the complainant, on an identified date, the family member had taken resident #001 on a leave of absence, and while on the leave, the family discovered that the resident had a bandage to an identified body area that the family was not aware of.

Progress notes review revealed that during the night of an identified date, resident #001 was observed to be picking and scratching an identified body area. The staff noted bleeding to the area, and the area was cleaned and a bandage was applied. The night RPN documented in the head to toe skin assessment of alteration to skin integrity which had developed as a result of the scratching.

Interview with the Nurse Manager of Operations revealed that the incident had occurred on the night shift. The night RPN had documented the incident, however the resident's family member was not called during the night, nor was a call placed to the family on the following day shift to inform them of the incident. The family came to the home in the afternoon to take the resident out on a leave of absence and discovered the wound at that time.

Interview with the DOC revealed that the home's process is to notify the family of any incidents or treatment provided, and the DOC confirmed that the resident's substitute decision maker was not given an opportunity to participate in the development and

implementation of the resident's plan of care. [s. 6. (5)]

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

During the inspection period, the inspector identified areas of non compliance related to continence care for resident #001. An expanded resident sample inspection was conducted which on an identified date, the inspector observed resident # 004 from 1105 hours to 1430 hours. The inspector observed that during this time period, resident #004 did not receive assistance with continence care.

A review of the plan of care for resident #004 revealed that the resident is to be toileted before (ac) and after (pc) meals and at bedtime (qhs). The resident is to be checked at least every 2 hours for incontinence.

Interview with PSW #107 who was assigned to provide care to the resident on the day shift of the identified date, revealed that they were called into work as the unit was short staffed, and they arrived on the unit at 1100 hours. PSW #107 reported that upon their arrival to the unit, they did not assist resident #004 with continence care. PSW #107 reported that after lunch services, they were in the process of toileting residents and confirmed that resident #004 was not toileted before or after their lunch meal.

Interview with RN #104 and RN #109 revealed that they provided personal care and continence care to the resident around 0900 hours A review of the resident's continence care with RN #104 confirmed that resident #004 did not receive continence change as per plan of care during the inspector's observation time period. [s. 6. (7)]

3. The MOHLTC received a complaint intake #011355-19 related to continence care and personal support services. According to the complainant, the family for resident #001 requested that no male PSW provide personal care to the resident, and a male PSW provided care to the resident on an identified date.

Record review of the resident's profile under "Special Instructions" in Point Click Care (PCC) states " no male care giver for performing care - AS PER POA REQUEST".

Interview with PSW #106, who was assigned to the resident on the identified date, confirmed that they provided care for resident #001. PSW #106 reported that they were aware that the family requested no male providers, however the resident was on their

assignment that day. The PSW reported that they have not provided care to the resident after the identified date.

Interview and review with the DOC confirmed that PSW #106 did not follow the resident's plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care; and 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 #3: 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,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who requires continence care products had sufficient changes to remain clean, dry and comfortable.

The MOHLTC received a complaint intake #011355-19 related to continence care. According to the complainant, resident #001 was found on three occasions to be incontinent and wearing two incontinent products.

Record review and staff interview revealed that on an identified date, the family of resident #001 arrived on the unit and found the resident to be incontinent and wearing a heavily soiled incontinent brief and another incontinent product placed on top. The family member informed the nursing staff and spoke with RN #101 about the incident. Interview

with RN #101 revealed that they observed resident #001 to be soiled and spoke with the assigned PSW #106 and requested that the PSW provide the resident with a shower. RN #101 reported that PSW #106 refused to assist the resident with a shower and the PSW left the unit. RN #101 reported that they went to assist the resident with the shower, and while providing care to the resident, RN #101 confirmed that the resident was wearing two incontinent products. RN #101 reported that it did not appear that the resident's incontinent product was changed.

Record review and staff interview revealed that on another identified date, the family member for resident #001 were called as the resident was required to return to the hospital. The family member arrived on the unit to assist with the transfer to the hospital. Upon arrival to the unit, the family member found the resident to be wearing two incontinent products, with one incontinent product heavily soiled.

Interview with PSW #105, who was assigned to resident #001 on the identified date, revealed that they arrived on the unit late as they were reassigned from another floor to come and assist on the unit. PSW #105 revealed that upon their arrival to the unit, they were told by the night PSW that residents on the assignment were changed and just required to be dressed and brought to the dining room. PSW #105 reported that they brought residents to the dining room for their meal, and after the dining service, they were assigned to provide the snack nourishments. PSW #105 reported that they did not assist resident #001 with continence care that morning, and was informed by the family member when they arrived at the home that the resident required changing. PSW #105 reported that they went into the room to assist the family member with the changes and found the resident wearing two incontinent products.

Interview with the Nurse Manger of Operations, and the DOC confirmed that during a family meeting, it was discussed and confirmed that on the two identified dates, resident #001 was found to be incontinent and wearing two incontinent products. The DOC confirmed that resident #001 did not receive sufficient changes to remain clean, dry and comfortable. [s. 51. (2) (g)]

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 residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that before discharging a resident under subsection 145 (1), the licensee provided a written notice to the resident, the resident's substitute decision maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the

resident.

A complaint was submitted to the MOHLTC by a family member of resident #002 related to the resident's wrongfully discharged from the long term care facility. The complainant reported other concerns , such as resident rights not respected, responsive behaviour not managed and personal care not provided appropriately.

Critical Incident System (CIS) reports was submitted to the MOHLTC regarding an incident of abuse between resident #002 and resident #005, and another CIS was submitted, related to resident to staff abuse. The resident was sent to Hospital where they stayed, and upon return to the home, was placed on one to one supervision.

A review of the home's incident reports revealed that on an identified date, resident #002 was aggressive with PSW #106, who provided one to one care and supervision to the resident. According to the chart review, and interview with RN #112, both PSW #106 and #111 were familiar with resident #002.

A review of resident #002's clinical record indicated the resident Cognitive Performance Score (CPS) indicated moderate impairment. On an later identified date their CPS score indicated progression of impairment. The progress notes indicated that in the last several months the resident presented with deteriorating responsive behaviour. A review of the responsive behaviour notes indicated that the Behavioural Support Ontario (BSO) team from the home (RN #112 and PSW#116) were working on on-going assessment of resident #002's behaviour together with the Psychogeriatric Resource team and Psychogeriatric Specialist for different approaches to manage the declining responsive behaviour.

Interview with resident #002's family member revealed that on an identified date, the home's Administrator informed them by phone that the resident was discharged from the facility. The Administrator informed the family that they should come to the home to collect the resident's belongings in 24 hours. The resident was transferred to the hospital and was on the waiting list to be transfer to another health facility.

Interview with the Care Coordinator (CC) from Central West LHIN at the hospital revealed that resident #002 stayed at the hospital until transfered to the health facility. The CC revealed that they were told by Wesburn Manor that the resident would not be accepted back to the home.

Interview with the Care Coordinator from Central East LHIN at the health facility indicated the resident is currently at the health facility, and an arrangement for placement into a long term care home will be completed, and this was discussed with the SDM.

A review of the progress notes revealed that on an identified date, the Administrator informed the family member of resident #002 that they were discharged from the home. The Administrator further documented that the family member who was the Substitute Decision Maker (SDM) should discuss the resident's treatment options with the discharge planner at the hospital. During the inspection period, the inspector was not able to interview the home's Administrator because they were absent from the home. The CEO of Operations with the City of Toronto was informed about the discharge and confirmed the written statement of the Administrator related to the reason for the discharge.

A review of the email communication between the home's Administrator and resident #002's SDM, indicated that resident #002 was discharged from the home the second day after they were transferred to hospital and resident #002's SDM was not provided a written notice setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. Interview with the DOC indicated that the home did not provide a written notice because it does not have a policy for notifying residents' SDM about the discharge and the home should create one. [s. 148. (2)]

Issued on this 13th day of August, 2019

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

Original report signed by the inspector.