Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 5, 2020	2020_654618_0009	002276-20, 002388-20	Critical Incident System

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

CECILIA FULTON (618)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 27, 28, 29, 2020.

The following Intake Logs and Critical Incident System (CIS) Reports, were inspected.
Log # 002276-20, CIS report #M612-000001-20.
Log # 002388-20, CIS report #M612-000002-20.

During the course of the inspection, the inspector(s) spoke with The Administrator, Registered Staff (RN/RPN), Personal Support Workers (PSW), and resident's Substitute Decision Makers (SDM).

During the course of this inspection the inspector observed Residents and resident care areas, and reviewed resident records and home policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 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. (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 there is a written plan of care for each resident that set out, clear directions to staff and others who provided direct care to resident #001.

This inspection was initiated to inspect resident injury of unknown cause identified in CIS #M612-000002-20.

Review of resident #001's written plan of care identified their abilities and interventions related to bed mobility and tasks involving bed mobility.

Interview with RPN #104 identified that they were aware of the level of assistance resident #001 required for bed mobility, but they were able to provide care involving bed mobility with less than the level of assistance identified in the written plan of care.

Interview with the Administrator confirmed that all tasks involving bed mobility, required the identified level of assistance and that the written plan of care did not provide clear direction regarding this.

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.

This inspection was initiated to inspect a fall of resident #002 reported in CIS report #M612-000001-20.

Record review revealed that resident #002 had an unwitnessed fall on an identified date.

Review of resident #002's plan of care identified fall prevention interventions.

Review of post fall documentation identified that not all the fall prevention interventions were in use at the time of this fall.

Interviews with staff #101 and #102 confirmed that resident #002 was not using the identified fall prevention strategy, because the identified equipment was not available. PSW #101 informed RPN #102 that they were not able to implement the identified fall prevention intervention, and was instructed to get the resident up for the day.

Interview with RPN #102 confirmed they gave this instruction to PSW #101 and they were aware that the identified intervention was not in use.

As a result of the non compliance identified for resident #002, the sample was expanded to include two more residents who's written plan of care included the identified intervention.

Inspector #618 observed that resident #006 did not have the identified intervention in use on an identified date. The resident was sitting in the lounge, wearing adequate footwear and had their walker in close proximity, but they were not using the identified intervention. Interview with PSW #103 confirmed that they should be using the identified intervention, but they were not at this time.

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 written plan of care for each resident sets out clear directions to staff and others who provide care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The Licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

This inspection was initiated to inspect injuries of unknown cause identified in CIS #M612 -000002-20.

Review of resident #001's written plan of care identified resident #001's abilities and interventions related to tasks involving bed mobility.

An interview with RPN #104, identified that they provided the identified care to resident #001, in a manner not consistent with the interventions identified in the written plan of care.

Interview with RPN #104 identified that they were aware of interventions identified in the written plan of care, but that they provided the identified care to resident #001, in a manner not consistent with the interventions identified in the written plan of care.

Interview with the Administrator confirmed the interventions as found in the written plan of care are what needs to be administered, and that RPN #104 failed to administer positioning of resident #001 in a safe manner.

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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

Issued on this 9th day of March, 2020

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

Original report signed by the inspector.