Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
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Original Public Report

Report Issue Date: December 6, 2022

Inspection Number: 2022-1607-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: City of Toronto Seniors Services and Long-Term Care (Union Station) c/o 55 John Street Toronto ON M5V 3C6

Long Term Care Home and City: Wesburn Manor
400 The West Mall Etobicoke ON M9C 5S1

Lead Inspector	**Inspector Digital Signature**
Nicole Ranger (189)	Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2022.12.21 22:24:08 -05'00'

Additional Inspector(s)
Helina Leung (741076)
Maya Kuzmin (741674)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 8, 2022
November 9, 2022
November 10, 2022
November 15, 2022
November 16, 2022
November 17, 2022

The following intake(s) were inspected:

- Intake: #00001349-22[CIS: M612-000002-22] related to fall of resident resulting in injury.
- Intake: #00002194-22[CIS: M612-000019-22] related to fall of resident resulting in injury.
- Intake: #00002887-22[CIS: M612-000005-22] related to unknown injury of a resident.
- Intake: #00004896-22[CIS: M612-000012-22] related to fall of resident resulting in injury.
- Intake: #00005001-22[CIS: M612-000017-21] related to unknown injury of a resident.
- Intake: #00005494-22[CIS: M612-000032-22] related to fall of resident resulting in injury.

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- Intake: #00006974-22[CIS: M612-000012-21] related to fall of resident resulting in injury.
- Intake: #00008204-22[CIS: M612-000025-22] related to fall of resident resulting in injury.
- Intake: #00005007-22 [CIS:M612-000007-22] related to staff to resident neglect.
- Intake: #00012235-22 Complaint- related to fall prevention and medication administration.

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control
Resident Care and Support Services
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed by staff related to routine practices and additional precautions.

Rationale and Summary

On November 8, 2022, PSW # 101 was observed walking in the hallway on an identified unit wearing a surgical mask that was ill fitting and not covering the chin, as ear strings were twisted.

The home's policy titled "Infection Control Policy Routine Practices IC-0501-00 " directed staff to wear their masks properly, which outlined that their mouth and nose must be covered.

PSW # 101 reported that IPAC process in the long term care home directs staff to wear their surgical without twisting it around the ears; they acknowledged they wore their surgical mask leaving their chin

exposed while walking in the hallway. They then adjusted the surgical mask to fit the correct way covering the chin.

Failure for PSW #101 to wear the mask correctly increased risk of transmission of infection to staff and residents.

Sources: Observations on Nov 08, 2022, policy titled "Infection Control Routine Practices IC-0501-00", interview with PSW #101.

[741674]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 351 (2) 1.

The licensee has failed to ensure that where an inspection report mentioned in clause (1)(a)(c) or (d) contains personal information, only a version of the report that has been edited by an inspector so as to provide only the finding and a summary of the evidence supporting the finding was posted.

Rationale and Summary:

On November 8, 2022, the inspector observed the Information board in the main floor hallway with the following Ministry of Long Term Care (MLTC) inspection licensee report posted:

- 2022_1607_0001, Licensee Report dated June 20, 2022.

The Acting Administrator reported only public reports should be posted. The Acting Administrator observed the inspection licensee reports on the board and proceeded to remove the report. They acknowledged that licensee reports should not be posted in the home, and that residents personal information in the reports was not protected.

Sources: Observation on November 8, 2022, interview with Acting Administrator.
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Date Remedy Implemented: November 8, 2022

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

Rationale and Summary:

On an identified date, PSW #103 found resident #001 on the floor asking for help. Resident #001 was assessed by the registered staff, transferred to hospital and diagnosed with an injury.

Resident # 001's written care plan required staff to apply a fall prevention intervention. Physiotherapist (PT) # 109 reported that the intervention has been in place since January 2021. Progress notes and RPN #110 reported that they assessed the resident post fall, and confirmed that the fall intervention was not in place at the time of the fall.

Failure to provide the fall prevention intervention placed resident #001 at risk for injury associated with falls.

Source: Progress notes, resident #001's written care plan, interviews with PSW# 103, RPN #110, and Physiotherapist #109.

[741674]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed by staff related to routine practices and additional precautions.

Rationale and Summary

The home followed local Public Health (PH) best practices for IPAC.

At the time of the inspection, the following IPAC practices were observed:

1. Hand Hygiene:
Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.4 (h) states that the

licensee shall ensure that the hand hygiene program includes support for residents to perform hand hygiene prior to receiving meals and snacks.

On November 8, 2022, observation of the lunch meal on an identified unit revealed staff did not assist resident #007, #008, and #009 with hand hygiene before or after their meals.

2. Personal Protective Equipment (PPE):
IPAC Lead stated that the staff are to ensure any reusable eye wear for infection control purposes are cleaned and stored correctly in their own individual shelves at the "Mask Changing station" in the recreation room, to avoid the spread of infection.

On November 8, 2022, an unlabeled face shield was observed on top of resident #010's memory display box in the hallway.

3. De-escalation of COVID-19 Outbreak Control Measures
Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 2.13 states that the licensee shall ensure that processes are established for the de-escalation of practices where the precautionary principle has been applied.

During the initial tour on November 8, 2022, the inspector observed Droplet/Contact Signage and caddies with PPE equipment on residents #011 and #012's door. On November 15, 2022, IPAC Practitioner stated that both residents were previously on isolation due to COVID-19, and were cleared in October 2022. They reported that the home's practice is to inform the unit nurse to remove signage and PPE supplies once the residents are out of isolation.

IPAC Lead and IPAC Practitioner acknowledged there were risk at the time of non-compliance related to staff not following the home's IPAC program and local public health direction.

There was a risk of infection transmission to residents when they were not assisted with hand hygiene prior to their meal. There was a potential contamination risk when the face shield was left unattended, and that the staff did not implement the de-escalation process once residents were out of isolation.

Sources: Observations conducted on November 8, 15, 2022, interviews with RN #122, PSW #120, PSW #121, IPAC Lead and IPAC Practitioner.

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WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (3) 4.

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

Rationale and Summary:

Resident #001 experienced two falls: one with no change in functional or physical status other than a skin impairment; and a second fall where family member requested for staff to transfer the resident to the hospital.

Hospital notes indicated that on an identified date, a diagnostic test was conducted on resident #001 which revealed an injury. Resident #001 remains in hospital at the time of this inspection.

Acting Director of Care (A/DOC) # 111 acknowledged that the resident experienced a significant change in their health condition post fall on an identified date, and that a critical incident report should have been submitted to the Director.

Sources: resident #001's clinical records, interview with A/DOC # 111.

[741674]