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 District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: July 14, 2023	
Inspection Number: 2023-1607-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: City of Toronto	
Long Term Care Home and City: Wesburn Manor, Etobicoke	
Lead Inspector Parimah Oormazdi (741672)	**Inspector Digital Signature** Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2023.07.19 10:34:46 -04'00'
Additional Inspector(s) Dorothy Afriyie (000709)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 21 - 23, 26 - 27, 2023
The inspection occurred offsite on the following date(s): June 26, 2023

The following intake(s) were inspected:

- Intake: #00087689 was related to Physical abuse/improper transfer
- Intake: #00088165 was related to continence care, skin and wound care and dealing with complaints

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

Resident Care and Support Services
Infection Prevention and Control

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)
Non-compliance with: FLTCA, 2021, s. 184 (3)

The Licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, the licensee was required to ensure that masking requirements as set out in the COVID-19 guidance document for long-term care homes in Ontario, updated March 31, 2023, were followed. Specifically, as of June 23, 2023, homes must ensure that all staff comply with masking requirements at all times, even when they are not delivering direct patient care, including in administrative areas.

Rationale and Summary
Through two different dining service observations, it was observed that two staff members did not comply with universal masking requirements. Their masks were not covering their nose while they were serving food to residents.

The two staff members acknowledged that medical masks should cover the nose and they corrected their mask wearing soon after they were notified. The Infection Prevention and Control (IPAC) practitioner confirmed that staff were expected to wear a medical mask covering the nose and mouth when interacting with residents.

Due to the home not ensuring that the universal masking requirements as set out in the Minister's Directive were followed, there was risk of infection transmission.

Sources: Dining service observations, interviews with staff members and the IPAC practitioner, Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, home's signage "DO'S and DON'TS OF SAFE MASK HANDLING".

[741672]

Date Remedy Implemented: June 23, 2023

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was revised when their care needs changed following a significant change in status.

Rationale and Summary
A complaint was submitted to the Director related to concerns with the care that was provided to a resident. The resident's Substitute Decision Maker (SDM) had reported previously that the resident was prone to an infection. Following a return from hospital, the resident was assessed due to a significant change in their status. However, their care plan did not address the infection or interventions to monitor resident and ensure progress of treatment.

A Registered Nurse (RN) and a Registered Dietitian (RD) indicated that the resident's care plan should have been revised and updated to include goals and interventions for recurrent infection following their significant change in status. The Director of Nursing (DON) confirmed that care plan should have been updated during an active infection to capture appropriate interventions and address the infection in a timely manner.

Failure to revise the resident's care plan regarding the infection put them at increased risk of delay in treatment and reoccurrence of infection.

Sources: The resident's clinical records, the resident's Assessment Instrument Minimum Data Set (RAI MDS), interviews with an RN, RD and the DON.
[741672]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident had occurred, immediately reported the suspicion and information upon which it was based to the Director.

Rationale and Summary
The home submitted a Critical Incident (CI) report to the Director reporting the allegation of abuse from a Personal Support Worker (PSW) to a resident. The CI stated the alleged abuse towards the resident occurred on a certain date.

The Social Worker received an email from the resident's family informing them about the allegation of abuse. The Social Worker acknowledged that they did not forward the email to the management in a timely manner.

The DON and the Social Worker both acknowledged that the incident should have been reported immediately to the Director.

The home's failure to report to the Director immediately after becoming aware of the allegation of abuse of the resident, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: Interviews with DON and Social Worker, record review of the resident's progress notes and risk management, and LTCH Zero Tolerance of Abuse and Neglect policy.
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