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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: March 20, 2024	
Original Report Issue Date: March 8, 2024	
Inspection Number: 2024-1607-0001 (A1)	
Inspection Type: Critical Incident	
Licensee: City of Toronto	
Long Term Care Home and City: Wesburn Manor, Etobicoke	
Amended By Ryan Randhawa (741073)	**Inspector who Amended Digital Signature** Ryan Randhawa Digitally signed by Ryan Randhawa Date: 2024.03.20 12:54:04 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Change NC #001 from a Written Notification (WN) to Non-Compliance Remedied (NCR)

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Lead Inspector Ryan Randhawa (741073)	**Additional Inspector(s)** Amal Ahmed (000819)
Amended By Ryan Randhawa (741073)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
Change NC #001 from a Written Notification (WN) to Non-Compliance Remedied (NCR)

INSPECTION SUMMARY

The inspection occurred on the following date(s): February 23, 26-29, 2024, and March 1, 2024 with February 23, 26-27, 29, 2024, and March 1, 2024 conducted on-site and February 28, 2024 conducted off-site.

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The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00105566 - [CI: M612-000001-24] - was related to outbreaks
- Intake: #00107586 - [CI: M612-000005-24] - was related to falls prevention and management

The following intake(s) were completed in this CI inspection:

- Intake: #00102011 - [CI: M612-000017-23], Intake: #00106796 - [CI: M612-000003-24], Intake: #00106888 - [CI: M612-000004-24] - were related to fall prevention and management
- Intake: #00104152 - [CI: M612-000020-23] - was related to outbreaks

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

Infection Prevention and Control
Falls Prevention and Management

AMENDED INSPECTION RESULTS

(A1)
The following non-compliance(s) has been amended: NC #001

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC). The home has failed to ensure that Routine Practices were implemented in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, hand hygiene, including the four moments of hand hygiene, as required by Additional Requirement 9.1 (b) under the IPAC standard, and failed to ensure personal protective equipment (PPE) was used in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard) as required by Additional Precaution 9.1(f) under the IPAC Standard.

Rationale and Summary

i. During lunch time in the dining room on a unit, a volunteer was observed to have greeted multiple residents with hand to hand contact, hugged multiple residents, moved a chair to sit on and assisted a resident with feeding. The volunteer did not perform hand hygiene between coming into contact with multiple residents while their hands were touching residents.

The volunteer acknowledged that they should have performed hand hygiene between contact with the different residents.

The IPAC Lead and Director of Care (DOC) acknowledged that the home's expectation was to perform hand hygiene before and after contact with different residents.

Failure of the volunteer to perform hand hygiene, following the four moments of hand hygiene between resident interactions increased the risk of infection transmission.

Sources: observations; review of "IPAC Standard for Long-Term Care Homes April 2022"; the home's policy titled "Hand Hygiene" published 01-06-2021, IC-0606-01; interviews with volunteer, the IPAC Lead, and DOC. [741073]

Rationale and Summary

ii. A Personal Support Worker (PSW) was observed entering a resident's room with no eye protection or n95 respirator. Signage on the residents' room entrance indicated they were on enhanced droplet/contact precautions. The PSW acknowledged that the room they entered required additional precautions to be

taken and confirmed that they entered the room without donning required PPE such as eye protection and n95 respirator as indicated on the signage.

The IPAC Lead acknowledged that when interacting with a resident in their room who was on enhanced droplet/contact precautions, all staff were expected to wear gloves, gown, along with N95 respirator and eye protection.

Failure to follow additional precautions increased the risk of infection transmission.

Source: Observations; review of "IPAC Standard for Long-Term Care Homes April 2022"; and interviews with PSW, the IPAC Lead, and DOC. [741073]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to report a critical incident after normal business hours using the Ministry's method for after hours emergency contact.

Rationale and Summary

On January 1, 2024, a COVID-19 outbreak was declared. On January 2, 2024, an outbreak critical incident report was submitted by the home. The home did not use

the Ministry's method for after hours emergency contact.

A Nurse Manager confirmed that the home submitted a critical incident report the day after the outbreak was declared and did not call the Service Ontario After-Hours Line.

Failure to report the outbreak critical incident after normal business hours using the Ministry's method for after hours emergency contact provided minimal risk to residents.

Sources: Critical Incident Reports M612-000001-24; MLTC Reporting Requirements - reference sheet; interview with Nurse Manager, IPAC Lead, and DOC. [741073]

(A1)
The following non-compliance(s) has been newly issued: NC #001

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. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer

necessary; or

The licensee has failed to ensure that a resident's plan of care was revised when the care set out in the plan of care was no longer necessary.

Rationale and Summary

A resident's plan of care indicated that the resident required a falls prevention and management intervention.

An interdisciplinary care plan review meeting was held for the resident where it was established that the fall prevention intervention was no longer necessary as the resident was no longer at a high risk for falls and had not had a fall in over a year. The fall prevention intervention was to be removed from the plan of care.

The fall prevention intervention was discontinued, however the plan of care was not revised. The Resident Assessment Instrument (RAI) Lead back up, a Registered Nurse (RN), and the DOC indicated that the care plan should have been updated by the RN at the time of the care plan review meeting.

There was low risk to resident #001 when their care plan was not revised to reflect their assessed needs for fall prevention and management given that the appropriate care was provided.

Sources: resident #001's clinical records; CIS: M612-000005-24; care plan review rounds; interviews with PSW, RN, RAI Lead back up, DOC and others. [741073]
Date Remedy Implemented: January 24, 2024