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

Public Report

Report Issue Date: January 6, 2025

Inspection Number: 2024-1359-0004

Inspection Type:
Complaint
Critical Incident

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Weston Terrace Community, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 26 - 29, and December 2 - 6, 9 - 11, 2024
The inspection occurred offsite on the following date(s): December 6, 2024

The following Complaint intake(s) were inspected:

- Intake: #00125186 - Related to plan of care, toileting, positioning in wheelchair
- Intake: #00125646 - Related to missing personal items, alleged staff-to-resident financial abuse, responding to complaints
- Intake: #00130895 - Related to medication administration

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

- Intake: #00123077 [CI #2874-000047-24] - Related to an unexpected death
- Intake: #00123528 [CI #2874-000049-24] - Related to neglect of multiple residents
- Intake: #00124373 [CI #2874-000051-24] - Related to resident-to-resident physical abuse

- Intake: #00126236 [CI #2874-000055-24] - Related to an injury of unknown cause
- Intake: #00127404 [CI #2874-000059-24] - Related to disease outbreak
- Intake: #00128895 [CI #2874-000063-24] - Related to neglect, improper care, pain management/palliative care
- Intake: #00129200 [CI #2874-000065-24] - Related to fall with injury
- Intake: #00131026 [CI #2874-000073-24] - Related to staff-to-resident abuse

The following intakes were completed: #00124949 [CI #2874-000052-24], #00125879 [CI #2874-000053-24], #00127207 [CI #2874-000058-24], #00128569 [CI #2874-000062-24], #00128985 [CI #2874-000064-24], #00131541 [CI #2874-000074-24] related to falls, and #00130925 [CI #2874-000070-24] related to medication administration

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

Continence Care
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care related to responsive behaviours.

Rationale and Summary
A resident had responsive behaviours that could escalate when triggered. The resident's plan of care did not provide clear direction to staff on how to identity when a situation could escalate.

A Personal Support Worker (PSW), who often worked with the resident, stated that they did not know what signs to look for to prevent a situation from escalating.

The Behavioural Supports Ontario (BSO) lead acknowledged that the plan of care related to the intervention for the resident's behaviour was not clear.

Sources: Resident's clinical record, Interviews with a PSW, BSO lead and other relevant staff.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, strategies were implemented to respond to their behaviours.

Rationale and Summary
A resident had a history of responsive behaviour that placed co-residents at risk of harm or injury. As an intervention, the resident was assigned a one-to-one PSW 24 hours a day for the safety of themselves and co-residents.

On a specific date, the one-to-one PSW escorted the resident to the home's outdoor grounds but left the resident unattended with co-residents as they observed from the foyer. During this time, an incident occurred.

The BSO lead confirmed that the one-to-one PSW should have been close to the resident and intervened before the resident's behaviour escalated.

Failure to maintain one-to-one PSW support for the resident, placed co-residents at risk for harm and injury.

Sources: Resident's clinical records, the home's responsive behaviour management policy; Interviews with one-to-one PSW, BSO lead, and other relevant staff.

WRITTEN NOTIFICATION: LAUNDRY SERVICE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (a) (ii)

Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,

The licensee has failed to implement procedures to ensure that a resident's clothing was labelled within 48 hours of admission.

Rationale and Summary
A resident was admitted on a specific date. The home's record showed that the resident's clothes were not labelled until more than 48 hours later.

The Environmental Services Supervisor (ESS) confirmed that the resident's clothing were labelled more than 48 hours after they moved in.

Failure to promptly label and return the resident's clothing and personal items after admission may have exacerbated the resident's concerns about accurately tracking their clothing and personal belongings.

Sources: Resident's electronic records, Clothing and personal effect inventory records, Labelling of Clothing – Laundry Policy, Interviews with the resident, ESS and an Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system

s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that the home's influenza immunization program policy was implemented by an RPN.

Rationale and Summary
A Registered Practical Nurse (RPN) administered the influenza vaccination to multiple residents. The RPN documented the vaccination in the residents' medication administration record (MAR), however did not document in the immunization portal record. The residents subsequently received a second dose of influenza vaccine on a later date

The RPN stated that they did not document under the immunization portal record after the vaccination was administered to multiple residents. Interim Director of Care (DOC) confirmed that the RPN did not document appropriately as per the home's Influenza Immunization Program policy.

Failure to document administration of the vaccine as per the home's policy resulted in a medication error.

Sources: Home's policy "Influenza Immunization Program", residents' MAR, Interviews with the RPN and Interim DOC.

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a medication was administered to multiple residents in accordance with the directions for use specified by the prescriber.

Rationale and Summary
On a specific date, a second dose of a medication was administered to multiple residents. The residents had already received the medication at an earlier date. The residents were monitored, with no harm or side effects observed.

The residents' MAR indicated an order for the medication to be administered one time only. The home's Medication Incident Report indicated that a second dose was administered by error.

The RPN and Interim DOC stated that the residents were administered a second dose of the medication incorrectly.

Failure to ensure that the medication was administered to the residents in accordance with the directions for use specified by the prescriber resulted in the residents receiving an additional dose.

Sources: Medication Incident Report, residents' clinical records, Interviews with the RPN and Interim DOC.

COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Ensure that all staff across the facility who may interact with a specific resident while performing their duties are trained on identifying triggers to the resident, de-escalating them and protecting other residents.
1a) Maintain a record of the education provided, including the date, names of the attendees and their designation.
2) Provide education to all registered staff on a specific resident home area (RHA) on the home's policies related to prevention of neglect of residents.
2a) Maintain a record of the education provided, including the content, date, names of attendees, and the name of staff member(s) who provided the education.
3) Develop and implement an audit tool to monitor and document labwork orders for all residents on a specific RHA for 28 consecutive days.
3a) Maintain a record of the audits completed, including date, shift time, person completing audit, status of labwork orders. Also include results of audits and any actions taken related to the audit findings.
4) Retain all records until the MLTC has deemed this order has been complied.

Grounds
The licensee has failed to ensure that a co-resident was protected from physical abuse by a resident, and that multiple residents were protected from neglect by an RPN.

Section 2 of the Ontario Regulation (O. Reg.) 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Section 7 of the O. Reg. 246/22 defines neglect as the failure to provide a resident

with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
1) A resident had a history of physical aggression towards co-residents. Their behaviour often escalated if they were not immediately redirected.

On a specific date, the resident was physically aggressive to a co-resident resulting in injuries.

A Care Support Assistance (CSA) indicated the resident first became agitated towards the co-resident.

The BSO lead acknowledged that the resident should have been redirected away from the co-resident when they showed signs of agitation.

The co-resident indicated that they were in pain for days due to their injuries.

Failure to protect the co-resident from physical abuse by the resident resulted in pain and injury.

Sources: CI # 2874-000051-24, residents' clinical records, home's investigation notes, Interviews with a CSA, PSW, BSO lead and other relevant staff.

2) RPN #119 sent an email to an ADOC, with concerns that multiple residents were not having their routine labwork scheduled by RPN #118, and that RPN #118 also hid laboratory reports that were to be filed. The email provided more details for how these actions impacted two specific residents.

The ADOC confirmed RPN #118's actions were a pattern of neglect that placed

multiple residents at risk of a delayed response to a change in health status.

Failure to ensure multiple residents were protected from neglect by RPN #118 resulted in possible negative health outcomes.

Sources: Email from RPN #119, residents' clinical records, home's investigation notes, Interview with an ADOC.

This order must be complied with by February 12, 2025

COMPLIANCE ORDER CO #002 REPORTING CERTAIN MATTERS TO DIRECTOR

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Provide education to all registered staff on a specific RHA on the home's policies related to immediate reporting of suspected neglect of residents.
1a) Maintain a record of the education provided, including the content, date, name of attendees, and the name of staff member(s) who provided the education.
2) Retain all records until the MLTC has deemed this order has been complied.

Grounds
The licensee has failed to ensure nursing staff on a specific RHA immediately reported suspected neglect of multiple residents by RPN #118 that resulted in harm or risk of harm to the residents.

Rationale and Summary
RPN #119 sent an email to an ADOC, with concerns that multiple residents were not having their routine labwork scheduled by RPN #118, and that RPN #118 also hid laboratory reports that were to be filed.

The home's investigation notes indicated RPN #119 had spoken with RPN #118 multiple times over a specific period of time about their concerns, and that other nurses on the unit had also spoken with RPN #118 instead of immediately reporting the issue to the leadership team. RPN #119 had acknowledged that neglect of resident care should be reported immediately.

An ADOC confirmed RPN #118's actions were a pattern of neglect that placed multiple residents at risk of a delayed response to a change in health status.

Failure of registered staff to immediately report multiple instances of neglect that impacted multiple residents resulted in a delay before the home took any actions.

Sources: Email from RPN #119, home's investigation notes, Interview with an ADOC.

This order must be complied with by February 12, 2025

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

Toronto District
5700 Yonge Street, 5th Floor
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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.