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
Jun 1, 2021	2021_729615_0019	025428-20, 000667-21	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Westside
1145 Albion Road Etobicoke ON M9V 4J7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 10, 11, 12, 13, 14, 17 and 20, 2021.

The following intakes were inspected during this inspection:

Log #025428-20 related to personal support services, medication and reporting and complaints;
Log #000667-21 related to personal support services, medication, reporting and complaints, prevention of abuse, neglect and retaliation and infection prevention and control;
Log #004737-20 related to pest control and housekeeping.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Registered Nurse-Infection Prevention and Control Lead, the Environmental Manager, a Registered Practical Nurse, a Personal Support Worker, a Housekeeper, a COVID infection control screener staff, a complainant and a resident.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with, investigated and resolved where possible, and a response that complied with paragraph 3 provided within 10 business days of the receipt of the complaint.

A complaint was submitted to the Ministry of Long Term Care (MLTC) on a specific date, expressing care concerns of a resident. A record review of the home's investigation of the complainant's concerns were incomplete and there was no documented evidence that the home sent a response to the complainant within 10 business days of the receipt of the complaint. The Administrator could not provide the outcome of their investigation or a response letter sent to the complainant within 10 business days of the receipt of the complaint.

Sources: Complaint and home's investigation documentation and interview with the Administrator. [s. 101. (1)]

2. During the inspection of a complaint, a complainant forwarded an electronic mail (email) correspondence to the inspector regarding the home's Family Counsel concerns of resident's care and the operation of the home regarding COVID-19 protection sent to the Administrator on a specific date. At a later date, the Administrator replied to the Family Counsel member via email, stating in part, as they spoke on the phone the previous day, that they would report to the Family Counsel the actions taken at the next counsel's meeting which was 15 days later. During an interview, the Administrator said they could not provide the outcome of their investigation or a response letter to the complainant within 10 business days of the receipt of the complaint.

Sources: Family Counsel email correspondence and interview with the Administrator. [s. 101. (1)]

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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with, investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee has failed to carry out the "Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing And Access to Homes", related to COVID-19 screening protocols which included temperature checks of visitors.

The "Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing And Access to Homes" screening protocols versions effective February 16, 2021, and April 7, 2021, specified that visitors be actively screened on entry for symptoms and exposures for COVID-19, which included temperature checks and not be admitted if they did not pass the screening.

A complaint was submitted to the Ministry of Long Term Care (MLTC) on a specific date, expressing concerns that the home was not screening and taking temperature of visitors when entering the home. A review of the home's screening documentation for a period of three months was conducted during which the home was in the Grey-Lockdown level. There was no documented evidence that the home was performing temperature checks on visitors for a period of 14 days. During an interview, Registered Nurse-Infection Prevention and Control Lead, indicated that they could not provide documents for visitors' temperature checks for that period.

The home's failure to perform temperature checks on visitors entering the home posed an increasing risk of exposing residents to COVID-19.

Sources: complainant interview and documents, Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing And Access to Homes, effective February 16, 2021; Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing And Access to Homes, effective April 7, 2021; home's screening documentation, interviews with staff. [s. 174.1 (3)]

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 carry out every operational or policy directive that applies to the long-term care home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure to immediately forward to the Director a written complaint concerning the care of a resident or the operation of the long-term care home when they received it.

During the inspection of a complaint, a complainant forwarded an electronic mail (email) correspondence to the inspector regarding the home's Family Counsel concerns of resident's care and the operation of the home regarding COVID-19 protection sent to the Administrator on a specific date. A review of the Long Term Care Home Critical Incident System (CIS) reports website (LTCHome.net) showed that no CIS was submitted to the Director. When asked if the home had submitted a CIS to the Director, the Administrator said no.

Sources: LTCHome.net, Family Council email correspondence and interview with the Administrator. [s. 22. (1)]

Issued on this 1st day of June, 2021

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

Original report signed by the inspector.