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

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Amended Public Report (A1)

Report Issue Date October 20, 2022
Inspection Number 2022_1169_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Revera Long Term Care Inc.

Long-Term Care Home and City
Westside, Etobicoke

Inspector who Amended
Reji Sivamangalam (739633)

Inspector who Amended Digital Signature
Reji Sivamangalam Digitally signed by Reji Sivamangalam
DN: cn=Reji Sivamangalam, o, ou, email=Reji.Sivamangalam@ontario.ca, c=CA
Date: 2022.11.07 15:38:47 -05'00'

AMENDED INSPECTION REPORT SUMMARY

This public inspection report has been revised to reflect the new Compliance Due Date for CO #001 to December 30, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 15-16, 26-30, 2022.

The following intake(s) were inspected:

- Log #015707-21 (Critical Incident System (CIS) #2663-000050-21), #013318-21 (CIS #2663-000043-21) and #012564-21 (CIS #2663-000042-21) related to falls prevention and management.
- Log #011261-21 (CIS #2663-000036-21) and log #011107-21 (CIS # 2663-000035-21) related to transfers.
- Log #011785-21 (CIS #2663-000039-21) related to abuse.

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

- Falls Prevention and Management

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services

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 #01 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that additional precautions and standards under the Infection Prevention and Control (IPAC) program were followed by staff.

A staff member was observed entering and exiting a resident's room without the required personal protective equipment (PPE). The resident's door had droplet and contact precautions signage and instructions on how to don and doff PPE. The staff member indicated that the resident was not on droplet and contact precautions and they were not required to don PPE to enter the room.

The home's process to remove a resident from isolation precautions was that registered staff would remove the signage from the resident's door.

Another resident's door had contact precautions signage, and instructions on how to don and doff PPE. The staff member explained that the signage communicated to staff that additional precautions were required while providing care. Both the observed rooms did not require additional precautions and the signs should have been removed by registered staff.

The above-mentioned resident rooms were observed again without any signage posted at the door.

Sources: observations, review of the home's procedures on Process for Removing Isolation, interviews with staff and IPAC lead.

Date Remedy Implemented: September 29, 2022

[704759]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC #02 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 residents were supported to perform hand hygiene prior to receiving snacks as required by Additional Requirement, specifically 10. 4 (h) under the Infection Prevention and Control (IPAC) standard for Long-Term Care Homes.

Rationale and Summary

(i) Staff members were observed offering snacks to residents in a corridor during morning snack service. Support for the residents to perform hand hygiene prior to snack service was not observed. The staff member indicated that PSWs were responsible to assist in hand hygiene for residents using hand sanitizer or hand washing. RN and IPAC lead stated that support for resident's hand hygiene should be performed prior to meals and snacks.

Failing to assist residents with hand hygiene increased the risk of transmission of infection.

Sources: Observations, interviews with staff and IPAC lead.

The licensee failed to ensure that staff followed the home's hand hygiene program.

Rationale and Summary

(ii) According to the home's hand hygiene policy, all employees will perform hand hygiene at the point of care and will use alcohol-based hand rub as the preferred method of hand hygiene when hands are not visible soiled.

On a specific date, a staff member did not perform hand hygiene prior to serving snacks and assisting a resident inside their room. The IPAC lead indicated that staff were expected to perform hand hygiene prior to contact with the resident.

On another date, a different staff member did not perform hand hygiene between assisting four residents and after clearing a used cup during snack service. Both staff members and the IPAC lead indicated that hand hygiene should be performed when entering and leaving the resident's room and between contact with residents.

There was a risk of disease transmission when staff did not follow the home's hand hygiene program.

Sources: Observations, the home's hand hygiene policy, Interviews with staff and IPAC lead. [704759]

The licensee has failed to ensure that a hand hygiene program was implemented in accordance with the IPAC Standard for Long Term Care Homes, April 2022.

Rationale and Summary

(iii) A staff member provided afternoon snack to multiple residents without performing hand hygiene when entering and exiting resident rooms. They did not assist a resident to perform hand hygiene before consuming the afternoon snack.

The staff member stated that hand hygiene should have been performed when entering and exiting resident rooms and they did so prior to providing care to the resident, then served them snacks. The resident clarified that care was not provided prior to afternoon snack service, and the last time hand hygiene assistance was offered was prior to lunch service. The staff did not comply with the home's hand hygiene policy.

There was risk of infectious disease transmission to multiple residents when hand hygiene was not performed by staff and residents during snack service.

Sources: Observations, interview with staff, the Home's hand hygiene policy.

[740849]

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure implementation of protocols for infectious disease surveillance testing.

Rationale and Summary

(iv) It was observed that the screener conducts Rapid Antigen Tests (RAT) for two general visitors. After the samples were collected and collection swabs were swirled in the solution tubes, nozzle caps were not used to dispense the solutions into each testing device. The entire solution was poured in each testing device.

After the sample was collected, one of the general visitors was observed to be sitting at a resident's dining table while waiting for their RAT result during lunch time. No staff redirected the general visitor.

The screener reported that nozzle caps were not always used when dispensing the solution especially when they were busy. The RAT manufacturer instructions were only available in Italian. English instructions were not provided to screeners. IPAC Lead confirmed that a nozzle cap should have been used with three drops of solution dispensed into each testing device, written instructions were not available in English for staff to reference, and general visitors

should not be waiting for their RAT results at a resident's dining table. They should have been redirected to the designated waiting area.

IPAC Lead acknowledged that there was a risk to residents when RAT instructions were not followed, and English instructions were not provided to screeners. There was a risk to residents when general visitors entered the facility and interacted with residents in the dining room while waiting for RAT results.

Sources: Observations, interview with screener and IPAC Lead.

The licensee has failed to ensure that additional precautions and standards under the Infection Prevention and Control (IPAC) program were followed by staff.

Rationale and Summary

(v.) On an identified date, it was observed that the screener doffed PPE in the following order after conducting a RAT for two general visitors: gloves, goggles, and gown. The screener was unaware that the order that they doffed PPE was incorrect.

IPAC Lead acknowledged that the doffing procedure conducted by the screener was incorrect and there was risk of infectious disease transmission when correct doffing procedure was not followed.

Sources: Observations, interview with screener and IPAC Lead.

[740849]

WRITTEN NOTIFICATION INFECTION FALLS PREVENTION AND MANAGEMENT

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 49 (1)

The licensee has failed to ensure that the falls prevention and management program was implemented when the post-fall huddle for a resident was not completed.

In accordance with O. Reg. 79/10 s. 8 (1) (b), the licensee is required to ensure that a post fall huddle is conducted on the same shift that the fall occurred. Specifically, staff did not comply with the home's policy "Fall Prevention and Injury Reduction program".

Rationale and Summary

A resident had a fall. Post-fall assessment and progress notes indicated that a post-fall huddle was not completed. The staff stated that a post-fall huddle should have been completed after each fall. Staff did not comply with the home's Fall Prevention and Injury Reduction program policy when a post-fall huddle was not completed after the resident's fall.

There was no significant impact identified to the resident when staff did not comply with the home's policy to complete a post-fall huddle.

Sources: the home's Falls Prevention and Injury Reduction program, resident's progress notes and post-fall assessment, interview with staff.

[740849]

WRITTEN NOTIFICATION PLAN OF CARE

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (1) (c)

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff for bed mobility.

Rationale and Summary

A resident required assistance with bed mobility and was diagnosed with an injury to the right leg. Prior to the incident, a plan of care was implemented that specified extensive assistance for bed mobility with one to two persons.

The staff identified that the resident was sometimes assisted with one person depending on strength of the resident at the time of transfer, and individual staff member. The staff member reported that the resident required two-person assistance for bed mobility during the night. The resident received an inconsistent level of assistance for bed mobility.

The staff indicated that there was risk of harm to the resident while receiving assistance from one person when they required two persons for bed mobility, and that the written plan of care should have indicated clearly when one- or two-person assistance for bed mobility was required.

Sources: Resident's clinical records and progress notes, CIS report, interviews with staff.

[704759]

NC #05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (1) (a)

The licensee has failed to ensure that there was a written plan of care for a resident after assessment by the Physiotherapist (PT).

Rationale and Summary

The PT assessed a resident and recommended the use of a mobility device. The resident's falls risk care plan was not updated until they had a fall. The staff were verbally notified of the PT's recommendation. The staff acknowledged that the falls risk care plan should have been updated after the PT completed the assessment.

There was minimal risk to the resident as staff were aware of the PT's recommendation.

Sources: Resident's clinical records and progress notes, interview with staff.

[740849]

NC #06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (10) (c)

The licensee has failed to ensure that a resident's falls prevention plan of care was revised when the care set out in the plan has not been effective.

Rationale and Summary

A resident was diagnosed with a specific disease with impaired physical and cognitive ability. The staff stated that the resident was at high risk for falls. The resident had two falls, but no revisions were made to the falls prevention care plan. The goal for the resident's falls prevention care plan stated that the resident will remain free from falls through to the next review. The resident fell again on a later date and sustained an injury. The staff acknowledged that the resident's falls risk care plan should have been reviewed and revised when the goal was not met.

There was risk to the resident when the written plan of care was not revised after the goal was not met, as lack of interventions may lead to more falls.

Sources: CIS report, resident's clinical records and progress notes, interview with staff.

[740849]

COMPLIANCE ORDER #001 PLAN OF CARE

NC #07 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 6 (7)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with LTCHA, 2007 s. 6 (7)

The licensee shall:

1. Compile a list of residents who have suicidal ideations.
2. Conduct bi-weekly audits for residents with suicidal ideations for one month, or until no concerns are identified to ensure their plans of care are followed.
3. Conduct bi-weekly audits on resident #006 or one month, or until no further concerns are identified to ensure their falls risk plan of care is followed.
4. Conduct bi-weekly audits on residents #001 and #002 for one month to ensure their transfers plan of care is followed.
5. Maintain record of steps one to four, who completed the audit, date of the audit, outcome of the audit and action taken as a result of the audit.

Grounds

Non-compliance with: LTCHA, 2007, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

Rationale and Summary

(i) Resident #005 had a history of suicidal ideation and depressive episodes. The resident verbalized thoughts of suicidal ideation. Their plan of care stated to remove objects from their room that could be used for self harm. The resident attempted self harm with sharp objects.

The staff member was unaware of resident's plan of care to remove objects that could be used for self harm. The staff acknowledged that the resident's plan of care was not followed when the resident had access to sharp objects.

There was risk and harm to resident when the plan of care was not followed.

Sources: The resident's clinical records and progress notes, interview with staff.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan.

Rationale and Summary

(ii) Resident #006 was diagnosed with a disease with impaired physical and cognitive ability and was at high risk for falls. The resident required a mobility device to ambulate based on a Physiotherapist (PT) assessment.

The resident had a fall while ambulating without any assistive devices. The staff stated they were unaware that the resident required the mobility device to ambulate; therefore, no encouragement was provided.

There was harm to the resident as an injury was sustained that required interventions.

Sources: Resident's progress notes, interview with staff.

[740849]

The licensee has failed to ensure that the care set out in resident #001's plan of care for two-person assistance was provided during the resident's transfer.

Rationale and Summary

(iii) A staff member attempted to transfer resident #001 onto the toilet alone and the resident fell.

The resident required extensive two-person assistance during transfers.

Assistant Director of Care (ADOC) acknowledged that staff did not provide two-person assistance to the resident as specified in the plan of care.

There was an increased risk of falls and injuries when the resident was transferred without two-person assistance.

Sources: CIS report, resident's clinical records and progress notes, and interview with staff.

The licensee has failed to ensure that the care set out in resident #002's plan of care for two-person assistance was provided during the resident's transfer

Rationale and Summary

(iv) A staff member transferred the resident alone and the resident fell.

The resident required two-person assistance during transfers.

ADOC #102 acknowledged that staff did not provide two-person assistance to the resident transfers as specified in the plan of care.

There was an increased risk of falls and injuries when the resident was transferred without two-person assistance.

Sources: CIS report, resident's clinical records and progress notes, and interview with staff.

[739633]

This order must be complied with by December 30, 2022

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. Please include the inspection report # and the order or AMP #;
(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:

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: 1-866-311-8002
TorontoSAO.moh@ontario.ca

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

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.