Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Amended Public Report (A1)

Report Issue Date: February 16, 2023	
Inspection Number: 2023-1169-0002	
Inspection Type: Follow up Critical Incident System	
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**

AMENDED INSPECTION REPORT SUMMARY

The previously issued Compliance Order #001 from Inspection #2022-1169-0001 related to LTCHA, 2007, s. 6(7) was found to be complied and was added to the Inspection Report.

INSPECTION SUMMARY

The Inspection occurred on the following dates:
January 9, 10, 12, 13 and 16, 2023.

The following intakes were inspected:
- Intake: #00013401 - First follow up to the Compliance Order #001 from inspection #2022-1169-0001, LTCHA, s. 6 (7), CDD Dec 30, 2022
- Intake: #00013050 - [CIS: 2663-000013-22] - Altercation between residents resulting in injuries
- Intake: #00008977 - [CIS: 2663-000037-22] - Fall of resident resulting in injury

The following intakes were completed:
- Intake: #00013056 - [CIS: 2663-000019-22] - Fall of resident resulting in injury
- Intake: #00013069 - [CIS: 2663-000022-22] - Fall of resident resulting in injury
- Intake: #00008818 - [CIS: 2663-000035-22] - Fall of resident resulting in injury

- Intake: #00014224 - [CIS: 2663-000042-22] - Fall of resident resulting in injury
- Intake: #00016377 - [CIS: 2663-000046-22] - Fall of resident resulting in injury

Previously Issued Compliance Order

Previously Issued Compliance Order

The following previously issued Compliance Order was found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 6 (7)	2022_1169_0001	001	Reji Sivamangalam (739633)

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 53(1)1.

The licensee has failed to ensure that the falls prevention and management program was implemented when the 72 hour fall huddle was not completed on a resident as per the home's policy.

In accordance with O. Reg. 246/22 s.11 (1)(b), the licensee is required to ensure that an interdisciplinary huddle is completed within 72 hours of move-in to the home and upon the return from hospitalization.

Specifically, staff did not comply with the home's policies "Fall Prevention and Injury Reduction" (Index CARE5-O10.01 and Index CARE5-O10.02, last reviewed March 31, 2022).

Rationale and Summary

A resident was initially admitted to the home on a specified date, and was re-admitted on a specified date, after hospitalization following a fall and injury. The Director of Care (DOC) verified that staff were expected to complete interdisciplinary team huddles upon the resident's initial admission and re-admission from the hospital as per the home's Fall Prevention and Injury Reduction program policy, and this was not done.

There was no significant impact to the resident when staff did not comply with the policy.

Sources:

The home's Fall Prevention and Injury Reduction program policies (CARE5-O10.01, CARE5-O10.02, both last reviewed March 31, 2022), resident's progress notes and admission assessments, and interviews with Assistant Director of Care (ADOC) and DOC.

[739633]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2)(b)(i)

The licensee has failed to ensure that a resident's surgical wound was assessed.

Rationale and Summary

A resident underwent a procedure following a fall and was re-admitted from the hospital. Skin and Wound Care Nurse verified that staff did not complete an assessment of the site of the wound after the resident was re-admitted from the hospital.

The resident was at risk of infection not being identified, if any, and appropriate wound management techniques were not developed when the wound was not assessed.

Sources:

The home's Skin and Wound Care policy (CARE 12-O10.02, last reviewed March 31, 2022, resident's clinical records and interview with Skin and Wound Care Nurse.

[739633]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 56 (2) (b)

The licensee has failed to ensure that an individualized plan was developed and implemented for a resident for managing incontinence.

Rationale and Summary

A resident's continence assessment on a specified date, identified them as having occasional incontinence. The resident's plan of care did not have interventions to assist the resident with incontinence. ADOC, who was also the home's continence program lead verified that an individualized plan was not developed or implemented for the resident, to promote and manage their continence after the assessment.

When an individualized continence plan was not in place, there was a risk of not managing and promoting the resident's continence appropriately, affecting their quality of life.

Sources:

The home's Continence Care policy (Index CARE2-O10-02, last reviewed March 31, 2022), resident's assessments and written plan of care, and interview with PSWs, ADOC and DOC.

[739633]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 56 (2)(h)(i)

The licensee has failed to ensure that a resident was provided with an incontinent product based on

their individual assessed needs.

Rationale and Summary:

Two Personal Support Workers (PSW) stated that a resident was using a specific incontinent product for managing their incontinence. The home's "Continence Care" policy directed the staff to determine the appropriate incontinent product based on the resident's individual assessed needs. ADOC and DOC verified that an assessment was not completed before the resident was provided with the incontinent product.

The resident was at risk of using an inappropriate product to manage their incontinence when an assessment was not completed to determine the required product.

Sources:

The home's Continence Care policy (Index CARE2-O10-02, last reviewed March 31, 2022), resident's assessments, and interviews with PSWs, ADOC and DOC.

[739633]

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 59 (b)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #001 and #002.

Rationale and Summary

Residents #001 and #002 had histories of inappropriate behaviours towards other residents.

On a specified date, resident #002 was moved into resident #001's room as a roommate. Approximately two weeks later, resident #002 reported resident #001 behaved inappropriately towards them. Resident #002 subsequently initiated a physical altercation with resident #001. Resident #001 was moved to another room and 1:1 monitoring was initiated for resident #002. On the following day, resident #001 went to resident #002's room and initiated a physical altercation with resident #002.

According to Behavioural Support Ontario (BSO) Lead's note on the aforementioned date, 1:1 staff was called to monitor resident #002. The 1:1 was to be continued for 72 hours for safety.

Resident #001's physician noted episodes of behaviour altercations between the two residents, and it was an inappropriate assignment of roommate.

Registered Practical Nurse (RPN) acknowledged that it was not a good idea to put residents #001 and #002 in the same room because they both exhibit responsive behaviours. RPN could not recall if residents #001 or #002 were on 1:1 monitoring at the time of the incident, but stated if they did, the incident would not have happened.

Charge Nurse (CN) reported the home usually implemented 1:1 monitoring for 72 hours, and then would follow the physician's orders for a resident's responsive behaviour. Their decision to have ongoing 1:1 monitoring is dependent on the risk to other residents and consultation with the physician.

ADOC advised they usually start the 1:1 whenever the behaviour occurred, and they continue the 1:1 monitoring. After discussion with the doctor and interdisciplinary team about the risk involved, then they may continue the 1:1. It also depends on if the 1:1 is ordered by the physician.

The Home's Dementia Care – Responsive Behaviour Procedure policy specified for the resident offender, 1:1 monitoring is initiated utilizing the interdisciplinary team; a schedule will be built resulting in direct supervision of the resident offender until triggers and risks are identified and managed.

By having two residents with histories of inappropriate behaviours, without the implementation of ongoing 1:1 monitoring following the initial incidents of responsive behaviours, this placed residents #001 and #002 at risk of physical harm and injury.

Sources

Review of CIS report 2663-000013-22, resident #001 and #002's progress notes, Home's Dementia Care – Responsive Behaviour Procedure policy (CARE 3.0102, last reviewed March 31, 2021) and interviews with RPN, CN and ADOC.

[741076]

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

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The license shall:
(a) Ensure all agency staff are trained on the proper use of personal protective equipment (PPE) prior to working a shift in the home. Maintain a record of training received, including but not limited to, name of staff members and designation, date of training and content of training received;
(b) Conduct random audits of agency staff related to the use of PPE on day, evenings and night shifts for a period of three weeks; and
(c) Maintain a record of the aforementioned audits, including the dates and times of the audits, the name(s) of the auditor, the names and designation of staff audited, results of audits and actions taken.

Grounds

The licensee has failed to implement any standard or protocols issued by the Director with respect to infection prevention and control.

The IPAC Standard for Long-Term Care Homes (April 2022), s. 9.1 (d) states the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program to include proper use of PPE, including appropriate selection, application, and removal.

On a specified date, agency PSW #114 was inside a room with resident #004 wearing only a surgical mask. There was signage on the door requiring gloves, a gown, an N95 mask, and eye protection. PSW #114 stated that they discarded the PPE just before they finished their shift and re-entered the room. Agency PSW #115 was observed entering the room and attending to the resident without wearing eye protection and acknowledged that they were expected to wear eye protection. The resident's progress notes indicated that the resident was on droplet and contact precautions. Registered Nurse (RN) and Infection Prevention and Control (IPAC) Manager confirmed that the resident was on droplet and contact precautions, and staff members were required to don gloves, gowns, N95 and eye protection when entering the room and attending to the resident.

On a specified date, agency PSW #119 was observed wearing a surgical mask under the N95 mask while providing care to resident #005. The IPAC Manager reported that PSW #119 should not have been wearing a surgical mask under the N95 mask as this breaks the seal of the N95 mask which puts the staff and residents at risk of contracting infection.

There was a risk of disease transmission when agency PSWs did not wear appropriate PPE.

Sources

Observations, resident #004's progress notes, interview with PSWs #114, 115, RN, and IPAC Manager.

[741076]

This order must be complied with by March 20, 2023

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

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

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.