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

# Original Public Report

**Report Issue Date:** June 7, 2023

**Inspection Number:** 2023-1169-0003

**Inspection Type:**
Complaint
Follow up
Critical Incident System

**Licensee:** Revera Long Term Care Inc.

**Long Term Care Home and City:** Westside, Etobicoke

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Nicole Ranger (189) | Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2023.06.23 13:36:07 -04'00' |

**Additional Inspector(s)**
Matthew Chiu (565)
Atala Katel (000705)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8-12, and 15-17, 2023.

The following intake(s) were inspected:

- Intakes: #00002784 [Critical Incident System (CIS) #2663-000016-22], #00084256 [CIS #2663-000011-23], #00086443 [CIS #2663-000015-23] related to prevention of abuse and neglect.
- Intake: #00013052 [CIS #2663-000017-22] related to alleged improper/incompetent treatment.
- Intakes: #00015920 [CIS #2663-000045-22], #00018715 [CIS #2663-000002-23], #00020358 [CIS #2663-000004-23], #00023005 [CIS #2663-000008-23], #00084916 [CIS #2663-000012-23], #00085171 [CIS #2663-000014-23] related to falls prevention, unsafe transferring, and positioning techniques.
- Intake: #00085661 was a complaint concerning falls prevention, alleged improper care and neglect.
- Intake: #00087471 follow-up to Compliance Order #001 from inspection #2023-1169-0002.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance: Compliance Order #001 from inspection #2023-1169-0002 related to O. Reg. 246/22, s. 102 (2) (b), inspected by Matthew Chiu (565)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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 (5)

The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development of their plan of care related to their fall.

**Rationale and Summary:**
Resident #001 had cognitive impairment and they had a SDM for their care.

Personal Support Worker (PSW) #105 found resident #001 on the floor and reported it to Registered Practical Nurse (RPN) #108. The resident experienced pain and had a change in their activity level following the fall. The following shift, staff notified the SDM of the change in the resident's condition. The SDM contacted the home the next day and was not notified of the resident's fall. The SDM spoke with staff again two days after the fall incident and later visited the resident. When the SDM asked if the resident had fallen, staff told them they had not. On the same day, the SDM requested to send the resident to the hospital for examination. The resident was diagnosed with an injury.

**Sources:** Resident's progress notes, assessment records; interviews with the SDM, PSW #105, RPN #109, and the Director of Care (DOC).

[565]

## WRITTEN NOTIFICATION: Plan of Care

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
**Non-compliance with:** FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that staff collaborated with each other in the assessment of resident #006's bathing care so that their assessments were integrated and were consistent with and complemented each other.

**Rationale and Summary:**
Resident #006's preferred method of bathing was to receive a shower. Record reviewed identified that resident #006 mostly received bed baths. PSWs #110, #113 and #115 stated it was unsafe when positioning resident #006 for a shower. The safety concern related to shower was not brought to the attention of registered staff. The DOC stated that when PSWs identify a safety concern, it should be communicated to registered staff so appropriate follow-up actions are taken to remedy the concern. The DOC confirmed that there was lack of collaboration amongst direct care staff.

Lack of collaboration placed the resident at risk for injury and their preferences for shower not being respected.

**Sources:** Resident's progress notes, assessment records, care plan; interviews with the PSWs #110, #113, #115, RPN #116, and the DOC.

[000705]

## WRITTEN NOTIFICATION: Transferring and Positioning Techniques

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
**Non-compliance with:** O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe positioning techniques when assisting resident #006.

**Rationale and Summary**
Resident #006 sustained a fall with injury when PSW #110 attempted to reposition the resident. The resident required two-person assistance to supervise and support the resident during repositioning for safety. The DOC and Assistant Director of Care (ADOC) #118 confirmed that staff did not use a safe positioning technique when assisting the resident.

When staff used unsafe positioning techniques, resident #006 sustained a fall with injury and required them to be transferred to hospital.

**Sources:** Resident's progress notes, assessment records; interviews with the PSW #110, Physiotherapist (PT) #111, ADOC #118 and the DOC.

[000705]

## WRITTEN NOTIFICATION: TRAINING

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
**Non-compliance with:** FLTCA, 2021, s. 82 (4)

The licensee has failed to ensure that staff received retraining on prevention of abuse and neglect at times or intervals provided in the regulations.

**Rationale and Summary:**
The home's Prevention of Abuse and Neglect policy indicates staff will receive training on prevention of resident abuse and neglect annually.

Review of training records for all staff revealed 51 per cent of staff did not completed training on prevention of abuse and neglect in 2022. The DOC and Infection Prevention and Control Manager (IPACM) acknowledged that all staff did not receive training on abuse and neglect annually.

**Sources:** Home's training records, policy titled "Resident Non Abuse Program", last reviewed March 2023; interviews with the DOC and IPACM.

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## WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1**

**Non-compliance with:** O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when resident #001 had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

**Rationale and Summary:**
The home used a post-fall assessment tool in Point Click Care for conducting post-fall assessment immediately after a resident fall.

PSW #105 found resident #001 on the floor and reported it to RPN #108. The resident was transferred to the hospital two days later and was subsequently diagnosed with an injury. A post-fall assessment was not completed until 12 days after the fall.

**Sources:** Review of resident's progress notes, assessment records; interviews with PSW #105, RPN #109, and the DOC.

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## WRITTEN NOTIFICATION: ADDITIONAL TRAINING - DIRECT CARE STAFF

**NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

**Non-compliance with:** O. Reg. 246/22, s. 261 (1) 1.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training provided for in the areas required under subsection 82 (7) of the Act related to falls prevention and management.

**Rationale and Summary:**
The home provided their annual falls prevention and management training to direct care staff using in-person education sessions in year 2022. There were 69 direct care staff, approximately 56 per cent, who did not receive the training as required.

**Sources:** Staff training records; interviews with the IPACM and DOC.

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## COMPLIANCE ORDER CO #001 DUTY TO PROTECT

**NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
**Non-compliance with:** FLTCA, 2021, s. 24 (1)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:

(A) Conduct a meeting with the PSW and registered staff assigned on an identified unit, to review the home's policy to promote zero tolerance of abuse and neglect.
- Maintain a record of the meetings completed, including but not limited to, date of meeting and staff who conducted the meeting, staff attendance, and the materials reviewed.
(B) Conduct random audits of PSW #119's provision of care to residents, to ensure adherence with the home's policy on abuse; and the residents' right to be treated with dignity and respect for a period of three weeks.
- Maintain a record of the audits completed, including but not limited to, date of audit, person completing the audit, staff and resident audited, outcome and actions taken as a result of any deficiencies identified.

**Grounds**
The licensee has failed to ensure that resident #001 was not neglected by staff, and resident #003 was protected from abuse and not neglected by PSW #119.

**Rationale and Summary:**
For the purposes of the Act and the Regulation:
- "Neglect" means 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;
- "Emotional abuse" means any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident; and
- "Verbal abuse" means any form of verbal communication of a threating or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well being, dignity or self worth, that is made by anyone other than a resident.

(A) Staff interview and home's falls prevention policy indicated that after unwitnessed fall of a resident, their care and treatment should include at least the following that related to their fall:
- Assessments such as post-fall assessment, post-fall huddle, fall risk assessment, fall risk screen assessment, head injury routine, referral for physiotherapy assessment;
- Communication to staff during shift exchange and have staff to monitor the resident every shift for 72

hours, including pain if relevant; and
- Notify the resident's SDM and physician regarding their fall.

PSW #105 found resident #001 on the floor and reported it to RPN #108. By the time they returned to the resident, they found them sitting on their bed, experienced pain and had a change in their activity level following the fall. Resident #001 did not receive the above-mentioned assessments related to their fall, the fall was not communicated during shift exchange to other staff, and the resident's SDM and physician were not notified of the fall. The resident received medication for their pain and stayed in bed until they were sent to the hospital for examination two days later as requested by the SDM. The resident was diagnosed with an injury and required surgical interventions.

Resident #001 was not provided with the treatment, care, and assistance as required post-fall, and the DOC acknowledged the resident was neglected by staff. The non-compliance caused delayed treatment to their injury and impact on their health as the resident was in pain before they were transferred to the hospital two days after their fall.

**Sources:** Resident's progress notes, assessment records, home's investigation notes and policy index #CARE5-O10.05, titled "Fall Prevention and Injury Reduction, Post -Fall Management", reviewed date March 31, 2023; interviews with the SDM, PSWs #105 and 106, RPN #109, and the DOC.
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(B) RN #122 was assisting a resident and heard a voice of PSW #119 shouting. When RN #122 entered resident #003's room, they found resident #003 crying, shaking and visibly upset. Resident #003 reported that PSW #119 started to speak to them in a loud tone, stating that it was the resident's fault they required frequent assistance with toileting that shift.

PSWs #120, #121, and RPN #126 also heard the shouting, entered resident #003's room and observed the resident shaking and crying. PSW #119 returned to the resident's room against the direction of RN #122. RPN #126 reported that they instructed PSW #119 to leave the room and PSW #121 provided care to the resident for the remainder of the shift.

PSW #119 confirmed that an incident occurred with resident #003, and that they was disciplined related to verbal and emotional abuse of resident #003.

The DOC acknowledged that the actions PSW #119 displayed to the resident constituted verbal and emotional abuse, and disciplinary measures were taken.

A review of the CIS report revealed that an additional incident of neglect occurred between resident #003 and PSW #119.

On an identified date, PSW #119 was assigned care to resident #003. The resident rang the call bell. PSW #124 attended to the resident who requested assistance with personal care. PSW #124 reported that they informed PSW #119 that the resident required assistance. PSW #119 did not respond to the resident's request, and the resident ran the call bell again, which was not responded to for 52 minutes. During this time, RN #122, PSW #123 and PSW #127 reported that PSW #119 was aware that resident required assistance to changed.

PSW #119 confirmed that they failed to return to resident #003 in a timely manner to assist them with personal care, and that they were disciplined related to neglect and improper care of resident #003.

The DOC acknowledged that the actions of PSW #119 constituted neglect and disciplinary measures were taken. The DOC also confirmed that this was the second incident of abuse/neglect related to resident #003.

The home's prevention of abuse and neglect policy indicates that the home has a zero tolerance for abuse and neglect. The inspector reviewed PSW #119 employee file and noted a pattern of disciplinary action related to abuse.

**Sources:** Resident #003's care plan, progress notes, home's investigation notes, policy on Resident Non Abuse, last reviewed March 2023, CIS #2663-000016-22, CIS #2663-000011-23; interviews with PSW #120, PSW #121, PSW #119, PSW #123, PSW #124, PSW #127, RN #112, RPN #126, the DOC and other staff.

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**This order must be complied with by** July 24, 2023

## COMPLIANCE ORDER CO #002 REQUIRED PROGRAMS

**NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
**Non-compliance with:** O. Reg. 246/22, s. 53 (1) 1.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The Licensee shall:
(A) Conduct meetings with all PSWs and registered staff to review the home's post-fall management policy, specifically roles, responsibilities and procedures for staff when a resident has fallen.

- Maintain a record of the meetings completed, including but not limited to, date of meetings and staff who conducted the meetings, staff attendance, and the materials reviewed.

**Grounds**
The licensee has failed to comply with their Falls Prevention and Management policy related to post fall management.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and be complied with.

**Rationale and Summary**
Specifically, staff did not comply with the home's policy index #CARE5-O10.05, titled "Fall Prevention and Injury Reduction, Post -Fall Management", reviewed date March 31, 2023, that upon discovering a resident has fallen, staff should:

- Stay with the resident until a registered staff arrives;
- Ensure that the resident is not moved prior to an assessment by registered staff;
- Use a mechanical lift to transfer the resident from the floor; and
- Immediately complete a post fall assessment following the fall.

(A) PSW #105 found resident #001 on the floor in their room. The staff member left the resident and went to notify registered staff on the unit. Upon their return, the resident was found sitting on their bed. Subsequent assessments indicated the resident had pain and change in their physical functioning. The resident was transferred to the hospital two days later and was diagnosed with an injury.

The DOC confirmed that the staff member should have stayed with the resident, as specified in their policy, and used the call bell to notify other staff members for assistance. Staff failed to stay with the resident, who self-transferred to their bed before they were assessed by a nurse was at risk of further injury.

**Sources:** Home's policy and investigation notes, resident's progress notes, assessment records; interviews with PSW #105, and the DOC.

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(B) Resident #002 had a fall and before the resident was assessed by the registered nurse, PSW #128 and PSW #129 manually transferred the resident.

Interviews with PSW #128, PSW #129 and RPN #130 confirmed that a nursing assessment was not completed prior to moving the resident.

The DOC acknowledged that staff did not follow the home's policy of moving the resident once the registered staff completed their assessment.

Moving the resident prior to a physical assessment in accordance with the home's policy, placed the resident at risk for further injury.

**Sources:** CIS #2663-000002-23, resident #002's progress notes, care plan, home's investigation notes and policy; interviews with PSW #128, PSW #129, RPN #130 and the DOC.

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(C) After resident #002 fell, PSW #128 and PSW #129 manually transferred the resident.

PSW #128 and PSW #129 confirmed that a mechanical lift was not used for transferring the resident.

The DOC acknowledged that staff did not follow the home's policy of using a mechanical lift after a fall.

Moving the resident manually without the use of a mechanical lift in accordance with the home's policy, placed the resident at risk for further injury.

**Sources:** CIS #2663-000002-23, home's policy, resident #002's progress notes; interviews with PSW #128, PSW #129, RPN #130, and the DOC.

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(D) Resident #002 fell on an identified date. RPN #130 reported that they were attending to a co-resident as they sustained an injury and required wound care and did not assess resident #002 post-fall until two hours later. RPN #130 confirmed that the post-fall assessment and head injury routine were not immediately completed prior to moving the resident.

The DOC acknowledged that staff did not follow the home's policy of assessing the resident at the time of the fall and completing the head injury routine as per schedule.

Failure to assess resident #002 immediately after the fall in accordance with the home's policy, placed the resident at risk for further injury.

**Sources:** CIS #2663-000002-23, home's investigation notes and policy, resident #002's progress notes; interviews with PSW #128, PSW #129, RPN #130 and the DOC.

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**This order must be complied with by** July 28, 2023

## COMPLIANCE ORDER CO #003 PLAN OF CARE

**NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**

**Non-compliance with:** FLTCA, 2021, s. 6 (7)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

The Licensee shall:

- Conduct random audits for residents who require fall prevention interventions, to ensure the interventions are implemented, on day and evening shifts for a period of three weeks.
- Maintain a record of the audits completed, including but not limited to, date of audit, person completing the audit, staff and resident audited, outcome and actions taken as a result of any deficiencies identified.

**Grounds**
The licensee has failed to ensure that the care set out in residents #002 and #006's plans of care was provided to the residents as specified in the plans.

(A) Resident #002 was at risk for falls and had a history of responsive behaviors. They required fall interventions to mitigate risk of falls, and one-on-one monitoring was ordered for safety to continue until the resident was assessed by specialized services.

On an identified date, resident #002 left their room ambulating independently and sustained a fall in the hallway. Multiple direct care staff confirmed that the fall interventions, and the one-on-one staff was not in place at the time of the fall and no monitoring of the resident was conducted prior to the fall.

During the inspection, the inspector observed resident #002 in their room with one-on-one staff present. The inspector observed the fall interventions were not in place. The one-on-one staff assigned to resident #002 reported the fall interventions were not in place for over a month. PSW #132 and RPN #130 observed and acknowledged that the fall interventions were not in place.

The DOC acknowledged that one-on-one staff and monitoring were not in place during the above-

mentioned fall, and staff did not follow resident #002's plan of care for falls prevention.

Failure to ensure the care set out in the plan of care was provided to resident #002 put the resident at risk of injury from a fall.

**Sources:** CIS #2663-000002-23, resident #002's progress notes, care plan, home's investigation notes; interviews with PSW #128, PSW#129, PSW #131, PSW #132, RPN #130, one-on-one staff #133, and the DOC.

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(B) Resident #006 required two-person assistance for bed mobility, dressing, hygiene, and grooming. On an identified date, staff observed the resident had new bruising. The home's investigation notes revealed that a staff member had provided personal care to the resident by themselves. PSW #112 stated they were not aware of the level of assistance the resident required and had provided personal care to the resident on their own, which included assisting the resident with bed mobility.

The DOC stated that the staff did not follow the plan of care when they provided care to the resident with one-person assistance, placing both the resident and staff at risk for injury.

Failure to provide care as specified in the plan of care placed resident #006 at risk for injury.

**Sources:** Resident's progress notes, assessment records, Point of Care documentation, home's investigation notes; interviews with PSW #112 and the DOC.

[000705]

(C) Resident #006 required their call bell to be within reach and wear a fall intervention as a part of their falls management strategies. Observations and staff interviews confirmed that:

- During two observations, the call bell was on the floor behind the resident's nightstand and was not within the resident's reach; and
- The second observation, the fall intervention was not provided to the resident.

The DOC confirmed that that resident #006 remained at risk of falls and those interventions should have been in place.

Nonadherence to plan of care regarding falls management interventions placed the resident at risk of falling and sustaining injuries.

**Sources:** Resident's progress notes, assessment records care plan; interviews with PSW #134, RPN #135, RPN #116, and the DOC.

[000705]

**This order must be complied with by** July 28, 2023

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

**Notice of Administrative Monetary Penalty AMP #001**

**Related to Compliance Order CO #003**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

**Compliance History:**

CO related to LTCHA, 2007 s. 6 (7) was issued on October 20, 2022, from inspection #2022_1169_0001.

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## 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.