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: September 13, 2023

Inspection Number: 2023-1169-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Westside, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Cindy Ma (000711)	Shuang Yu Ma Digitally signed by Shuang Yu Ma Date: 2023.09.14 14:57:16 -04'00'

Additional Inspector(s)
Rajwinder Sehgal (741673)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 24, 25, 28, 29, 30, 31, 2023 and September 1, 5, 2023

The following intake(s) were inspected:

- Intake: #00087227 - [IL-12851-AH/2663-000018-23] - Related to falls prevention and management
- Intake: #00091457 - [IL-14930-AH /2663-000021-23] - Related to Abuse
- Intake: #00094843 - Complaint related to air temperature, air conditioning requirements, maintenance services, pest control, dealing with complaints and plan of care
- Intake: #00090798 - Follow-up CO #001 from inspection #2023-1169-0003 - Duty to Protect
- Intake: #00090800 - Follow-up CO #002 from inspection #2023-1169-0003 – Required Programs (Falls)
- Intake: #00090799 -Follow-up CO #003 from inspection #2023-1169-0003 - Plan of Care

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1169-0003 related to FLTCA, 2021, s. 24 (1) inspected by Rajwinder Sehgal (741673)

Order #003 from Inspection #2023-1169-0003 related to FLTCA, 2021, s. 6 (7) inspected by Rajwinder Sehgal (741673)

Order #002 from Inspection #2023-1169-0003 related to O. Reg. 246/22, s. 53 (1) 1. inspected by Rajwinder Sehgal (741673)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (c)

The licensee has failed to ensure that a resident's care plan was revised when the intervention set out in the plan was ineffective.

Rationale and Summary

A resident's clinical records identified that they were a high risk for falls and required to utilize a specialized device as a part of their falls management interventions.

In speaking with the resident on a specified day, they reported that they were not utilizing the specialized device. The resident was identified to have intact cognitive function.

A PSW indicated that the resident was offered the specialized device after a fall but resident refused. PSW acknowledged that the resident's plan of care at the time of the inspection was not updated.

An Associate Director of Care (ADOC) confirmed that the resident had refused to utilize the specialized device since a specified day in July 2023. ADOC acknowledged that the resident's care plan should have been updated.

After being notified, the ADOC removed the intervention from the resident's care plan.

There was a low risk to the resident when the care plan was not updated since the care provided adequately met resident's current needs.

Sources: Resident's care plan; and interviews with resident; PSW and Associate Director of Care (ADOC) [000711]

Date Remedy Implemented: August 31, 2023

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that that a resident was protected from physical abuse.

Ontario Regulation (O. Reg.) 246/22 s. 2 (1), defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

A Critical incident (CI) was reported to the Director on a specified day in July 2023, related to an incident of resident-to-resident abuse.

Clinical records reviewed indicated that two residents were observed having an altercation which led to physical aggression. As a result, one of the residents sustained injuries.

One of the residents stated that they sustained injuries as a result of the other resident using physical force. This was confirmed during interviews with two Registered Nurses.

The Director of Care (DOC) verified the above mentioned incident constituted physical abuse.

There was physical impact to the resident when they experienced physical aggression by the other resident.

Sources: Residents' clinical records; Critical incident report; and interviews with residents, DOC and other staff
[000711]

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