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: January 30, 2024	
Inspection Number: 2023-1169-0005	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Westside, Etobicoke	
Lead Inspector Arther Chandramohan (000720)	Inspector Digital Signature Arther Chandramohan Digitally signed by Arther Chandramohan Date: 2024.02.09 14:10:40 -05'00'
Additional Inspector(s) Trudy Rojas-Silva (000759) Training Specialist present on Inspection, Iana Mologuina (763)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 14, 18, 20-22, 2023.
The inspection occurred offsite on the following date(s): December 19, 2023 and January 8-10, 2024.

The following intake(s) were inspected:
- Intake: #00096226 - Critical Incident (CI) #2663-000033-23 - related to falls.
- Intake: #00099313 - Critical Incident (CI) #2663-000040-23 - related to resident care and services.

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:

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The Licensee has failed to ensure that the written plan of care for resident #002, set out clear directions to staff and others who provided direct care.

Rationale and Summary

A resident had a change in condition and was sent to hospital, then later passed away in the hospital.

Review of resident's care plan and Kardex did not specify instructions related to specific personal care.

A Personal Support Worker (PSW) validated that resident had required assistance with a specific component of care since admission.

A PSW stated they were unaware that resident required the specific care and were not providing it.

Resident Assessment Instrument Coordinator (RAI-C) verified that the plan of care for resident did not give clear direction to direct care staff regarding the resident's specific care needs.

Director of Nursing (DON) verified that the expectation is for the plan of care to be updated, and written in a clear and concise manner that is reflective of resident's needs.

Sources: Interviews with PSWs, RAI-C, DON, and resident clinical records.

[000759]

WRITTEN NOTIFICATION: ORAL CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 38 (1) (a)
Oral care
s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;

The licensee failed to ensure that resident #002 received oral care to maintain the integrity of the oral tissue that includes, the cleaning of dentures.

Rationale and Summary

A resident was admitted to the home with existing oral care requirements.

Review of resident's care plan and Kardex did not provide necessary information related to oral care.

PSW stated resident's required oral care was not provided at bedtime.

Failure to provide resident with proper oral care placed them at risk for negative health outcomes.

Sources: Interview with PSW and resident's care plan and Kardex.

[000759]

COMPLIANCE ORDER CO #001 Plan of care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

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

- Provide education to registered staff #106, #108, #110 and, #112, including RD #113, on the process of assessing, communicating, and addressing changes in health condition; document the education, including the date and, the staff member who provided the education.

Grounds

The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary

On a specified date, it was noted that the resident had experienced a change in status and exhibited new health concerns. The resident's condition worsened and they were transferred to hospital. The resident passed away in hospital.

A PSW and Registered Practical Nurse (RPN) both verified that the resident had specific health requirements.

PSW stated they were unaware of resident's specific health status and had not been proving adequate care at bedtime.

RPN verified that they had not completed an assessment of resident at admission and did not communicate this to the following shift. The specific assessment was not completed for resident, and their care plan was not updated related to their specific care needs.

PSW noted that on a specified date, they had not provided the resident's care at bedtime. The next morning, PSW observed concerns with the resident's health status and reported it to registered staff.

Registered Dietitian (RD) received a verbal referral from RPN to reassess resident due to changes in status. RD observed resident and documented change in status, changes were made to resident's plan of care.

On a specified date, physician acknowledged that they were unaware of the change in the resident's specific health condition. They documented there were no new concerns with resident.

Based on the above evidence staff failed to collaborate with each other, on the resident's specific care needs and assessment, and when the resident experienced a change in health condition.

Sources: Interviews with PSW staff, RPN staff, RD, physician, review of physician's communication book, resident clinical record.

This order must be complied with by

February 9, 2024

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.