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
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Original Public Report

Report Issue Date: March 19, 2024
Inspection Number: 2024-1169-0001
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
Parimah Oormazdi (741672)	Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2024.03.20 14:23:11 -04'00'

Additional Inspector(s) Noreen Frederick (704758)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6-8, and 12-14, 2024

The following intakes were inspected during this Critical Incident (CI) Inspection:

- Intake: #00101021/ CI #2663-000041-23, intake: #00104653/ CI #2663-000046-23, intake: #00109140/ CI #2663-000012-24 and intake: #00106017/ CI #2663-000004-24 was related to Infection Prevention and Control (IPAC)
- Intake: #00109085/ CI #2663-000011-24 was related to improper care
- Intake: #00109454/ CI #2663-000018-24 was related to unexpected death

The following intakes were completed in this complaint inspection:

- Intake: #00108916 was related to fall prevention and management program

The following Compliance Order (CO) Follow up intakes were inspected:

- Intake: #00107903 - CO #001 under inspection #2023-1169-0005, FLTCA, 2021 - s. 6 (4) (a) Integration of assessments, plan of care, Compliance Due Date (CDD): Feb. 9, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1169-0005 related to FLTCA, 2021, s. 6 (4) (a) inspected by Parimah Oormazdi (741672)

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided

to the resident as specified in the plan.

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

Rationale and Summary
The resident's care plan indicated that they required more than one staff assistance for transfers.

A Personal Support Worker (PSW) stated that they attempted to transfer the resident alone and as a result the resident fell and sustained an injury. The Executive Director (ED) acknowledged that the resident was not provided with more than one staff assistance as specified in their care plan.

Failure to ensure that the resident was provided with care as set out in their care plan, placed the resident at risk for injury.

Sources: The resident's care plan, and interviews with the PSW and ED.
[704758]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by someone that resulted in harm or risk or harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report related to an incident of Improper / Incompetent treatment of a resident that results in harm or risk a few days later than the incident day. The ED acknowledged that it should have been immediately reported to the Director.

There was no risk to the resident when the LTCH did not immediately report improper or incompetent care of the resident to the Director.

Sources: CIS report , and an interview with the ED.
[704758]

WRITTEN NOTIFICATION: Dining and snack service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure that a resident was safely positioned while being fed.

Rationale and Summary
A PSW was observed feeding a resident at an improper angle. They acknowledged that this was an unsafe position. The Long Term Care Home's (LTCH) safe eating assistance handout specified to position residents sitting upright as close to 90 degrees as possible while feeding, and the Assistant Director of Care (ADOC) stated the same.

By not safely positioning the resident while being fed, there was a risk of aspiration.

Sources: Inspector's observations, interviews with a PSW and ADOC, and LTCH's safe eating assistance handout.
[704758]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246 / 22, s. 102 (7).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (b) states that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident / resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident / resident environment contact).

Rationale and Summary
(i) A Registered Nurse (RN) was observed entering and exiting a resident's room and they did not perform hand hygiene before or after resident / resident environment contact. They acknowledged inspector's observations. IPAC Manager stated that the staff were required to perform hand hygiene before and after resident / resident environment contact.

Due to staff's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: Inspector's observations, interviews with the RN and IPAC Manager, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

Rationale and Summary
(ii) A PSW was observed exiting a resident's room and they did not perform hand hygiene after resident / resident environment contact. They acknowledged inspector's observations. IPAC Manager stated that the staff were required to perform hand hygiene after resident / resident environment contact.

Due to staff's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: Inspector's observations, interviews with the PSW and IPAC Manager, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023). [704758]