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

Public Report

Report Issue Date: April 3, 2025
Inspection Number: 2025-1169-0002
Inspection Type: Proactive Compliance Inspection
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Westside, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18, 20, 21, 24 - 28, 31, 2025 and April 1 - 3, 2025
The inspection occurred offsite on the following date(s): March 19, 2025

The following intake(s) were inspected:

- Intake: #00142171 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices

Pain 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)
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 resident's written plan of care set out clear directions to staff and others who provided direct care to the resident.

The care plan for the resident stated that the resident required a specific intervention for their skin integrity. The Assistant Director of Care (ADOC) and Personal Support Worker (PSW) acknowledged the plan of care did not provide clear directions to staff on the required frequency to perform the intervention.

The care plan was revised on April 1, 2025, to include the frequency the intervention was expected to be performed.

Sources: Review of resident's clinical record and interviews with the PSW and ADOC.

Date Remedy Implemented: April 1, 2025

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
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,
(a) the planned care for the resident;

The licensee has failed to ensure that the planned care for a resident was included in their written plan of care.

A review of the resident's care plan revealed that instructions pertaining to the planned care of the resident were not written in their care plan.

Sources: Resident's care plan, and interview with the Registered Practical Nurse (RPN).

WRITTEN NOTIFICATION: Family Council

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (b)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;

The licensee has failed to ensure that the actions taken from the resident and family/caregiver experience survey were made available to the Family Council.

The Family Council (FC) confirmed that there was no record that the home provided Family Council with a copy of actions taken from resident/family caregiver experience survey. The Family Council meeting minutes did not include a copy of the actions taken from the resident/family caregiver experience survey.

Sources: Family Council minutes meetings for 2024, interview with the FC.

WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
The licensee has failed to ensure that doors residents do not have access to were kept closed and locked.

The inspector observed the stairways door on the resident home area was left unlocked. The Environmental Service Manager (ESM) stated that the security system failed and that the door monitoring with enhance rounds was not implemented as per the Long-Term Care Home's (LTCH) policy.

Sources: Inspector's observation, LTCH's policy "Maintaining a safe and Secure Environment" and interview with the ESM.

WRITTEN NOTIFICATION: Bathing

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that the resident received the bathing method of their choice.

A review of Point of Care (POC) records indicated that the resident's bathing preference was not provided to them.

Sources: Resident's clinical records, and Interview with the PSW.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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 were 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).

A PSW was observed entering a resident's room to provide nourishment without performing hand hygiene. The PSW acknowledged that they did not perform hand hygiene before entering the resident's room.

Sources: Inspector's observations, interviews with the PSW and IPAC standards for Long-Term Care Homes.

WRITTEN NOTIFICATION: Quality Improvement

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 3.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
3. The home's Medical Director.

The licensee has failed to ensure that the quality improvement committee included the home's medical director.

The home confirmed that the home's medical director was not part of the quality improvement committee.

Sources: Quality improvement committee meeting minutes, and an interview with

the Executive Director (ED).

WRITTEN NOTIFICATION: Quality Improvement

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

The licensee has failed to ensure that the quality improvement committee included a member of the home's pharmacy service provider.

The home confirmed that a member of the home's pharmacy provider was not part of the quality improvement committee.

Sources: Quality improvement committee meetings minutes, and interview with the ED.

WRITTEN NOTIFICATION: Quality Improvement

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee has failed to ensure that the quality improvement committee included at least one employee of the licensee who was a member of the regular nursing staff of the home.

The home confirmed at least one employee of the licensee who was a member of the regular nursing staff of the home was not part of the quality improvement committee.

Sources: Quality improvement committee meetings minutes, and an interview with the ED.

WRITTEN NOTIFICATION: Family Council

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee failed to ensure that a copy of the continuous quality improvement (CQI) initiatives report, required under O. Reg 246/22 r. 168 (1) was provided to the Family Council.

The FC confirmed that the home did not provide the Family Council with a copy of the CQI report. The Family Council meeting minutes did not include a copy of the home's CQI initiative report.

Sources: Family Council minutes meetings for 2024 and interview with the FC.

COMPLIANCE ORDER CO #001 Air Temperature

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Develop and implement a written process that identifies the immediate action(s) to be taken when the air temperature of the home is below 22 degrees Celsius (°C).
2) The process developed must include the following requirements:
- documentation of the action(s) taken to resolve the lower temperatures
- the name of the person who completed the action(s)
- the outcome of the action(s) taken
3) Retain all records until the Ministry of Long-Term Care (MLTC) has deemed this order has been complied with.

Grounds

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 °C.

A review of the LTCH's air temperature reports of a specific moth revealed that that the air temperatures fell below 22 °C in resident bedrooms and common areas over a four week period. The air temperature fell as low as 10.5 °C and no actions were taken to remedy the temperatures.

When the licensee failed to ensure that the air temperatures in the home were maintained at a minimum of 22 °C, residents were put at risk for discomfort and cold-related illnesses.

Sources: The LTCH's air temperature reports, and interview with the ESM.

This order must be complied with by May 2, 2025

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.