Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

## Amended Public Copy/Copie modifiée du public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 22, 2018 | 2018_484646_0011 (A2) | 017950-18 | Resident Quality Inspection |

### Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

### Long-Term Care Home/Foyer de soins de longue durée

Weston Terrace Care Community
2005 Lawrence Avenue West TORONTO ON M9N 3V4

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by IVY LAM (646) - (A2)

### Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***

**Changes made to the Inspection Report were the following:**
**- r. 36 resident #109 changed to resident #005, and**
**- r. 50 added the word "notes" after progress.**

**Issued on this 23rd day of November, 2018 (A2)**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

# Inspection Report under *the Long-Term Care Homes Act, 2007*

# Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486


## Amended Public Copy/Copie modifiée du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 22, 2018 | 2018_484646_0011 (A2) | 017950-18 | Resident Quality Inspection |

### Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

### Long-Term Care Home/Foyer de soins de longue durée

Weston Terrace Care Community
2005 Lawrence Avenue West TORONTO ON M9N 3V4

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by IVY LAM (646) - (A2)

## Amended Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection.**

**This inspection was conducted on the following date(s): July 18, 19, 20, 23, 24, 25, 26, 27, 30, 31 and August 1, 2, 3, 2018.**

**The following complaints were inspected concurrently during this inspection:**

**Log #016041-18, #016043-18, and #018456-18 - related to hot temperatures in the home**

**The following follow-up inspection was conducted:**

**Log #004666-18 related to ensuring the written plan of care sets out the planned care for the resident.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Program Team Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist (PT), Environmental Services Manager (ESM), Housekeeping/Laundry Supervisor, Housekeeping staff, Maintenance staff, Food Service Workers, Residents' Council President, Family Council Member, Residents, Family Members, Power of Attorneys (POA), and Substitute Decision Makers (SDM).**

**During the course of this inspection, inspectors conducted a tour of the home, observed residents' care, staff to resident interaction, dining room services, medication administration, reviewed resident health care records and home's records.**

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

**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Personal Support Services**
**Recreation and Social Activities**
**Residents' Council**
**Safe and Secure Home**
**Skin and Wound Care**

**During the course of the original inspection, Non-Compliances were issued.**
- **7 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 6. (1) | CO #001 | 2018_378116_0002 | 565 |

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

| Legend | Légende |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.)<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**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 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**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. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

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

This inspection was initiated for resident #007 related to potential side rail restraint from the resident observation during stage one of the Resident Quality Inspection (RQI); identified side rails were observed to be in use while when the resident was in bed.

Review of the resident's current care plan in a binder at the nursing station on an identified date indicated that for bed safety, the resident was to use identified side rails to support specified routine activities of daily living, and to keep their identified type of mattress in place for safety. Staff were also to apply side rails when the resident is in bed.

Review of resident #007's health records indicated that a Bed Safety Assessment was completed upon admission, which stated the resident uses bed rails.

Review of the home's policy titled Bed Rails, Policy #VII-E-10.20, current revision May 2017, stated:
- The Physiotherapist (PT)/Occupational Therapist (OT) will on a quarterly basis and with a significant change in resident condition, reassess resident for the removal or continued use of a bed rail.
- The Registered Nurse (RN) / Registered Practical Nurse (RPN) will refer residents upon move-in/quarterly to the PT/OT to assess if a bed rail for mobility and transfers is appropriate.
- The Personal Support Worker (PSW) will observe and monitor resident behaviour and report any restlessness or aggression to the registered staff and document as required.

Review of resident #007's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment since admission showed that the use of bed rails under devices and restraint used had not been checked off since admission to the time of inspection.

Interview with RPN #118 stated that once the MDS is checked off that the resident has a bed rail, it will trigger through MDS for the bed safety assessment

to be done for the resident every quarter. Review of resident #007's MDS and assessments showed that quarterly bed safety assessments were not done for resident #007.

Review of resident #007's progress notes showed that on an identified date, a physiotherapy assessment was done which stated resident #007 was unable to use bed rails, and the recommendation was to remove the bed rails.

The Bed Safety Assessment conducted on a subsequent identified date by RPN #118 and the PT showed that no bed rails were required for resident #007, and only one zone was assessed for bed entrapment which did not include the assessment with bed rails.

Interview with RPNs #118 and #119 indicated that the registered staff were informed that residents who use the abovementioned type of mattresses should have bed rails to keep the mattress in place, and that resident #007's bed rails were not removed.

Interview with the Environmental Service Manager (ESM) stated that they were provided instructions by the Associate Director of Care (ADOC) #145 to keep the bed rails for resident #007.

Interview with the physiotherapist (PT) stated that resident #007 needed bed rails because they are using an identified type of mattress. The PT stated that the Bed Safety Assessment done for resident #007 on the second identified date mentioned above was incomplete as they had not checked off the question for bed rail indicated and it was left blank. The PT stated it was the registered staff who completed the bed rail decision section and who had selected no bed rail required.

Interview with RPN #118 who completed the bed rail decision section of the Bed Safety Assessment on the second identified date stated that they had referred to the previous PT assessment on the first identified date, which said to remove the bed rails.

Review of resident #007's records, and interviews with RPNs #118 and 119 stated that the quarterly assessment of resident #007's bed safety assessment for bed rails were not done since admission. RPNs #118 and #119, and the PT stated that referral was not done to assess resident #007's bed safety and bed

entrapment zones when the bed rails were to be kept for the resident.

Interview with the Director of Care (DOC) stated that there was a lack of collaboration with the staff and others involved in the assessment of resident #007 's use of bed rails. [s. 6. (4) (a)]

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

The inspection was initiated for resident #005 in stage two of the RQI related to an identified staged pressure ulcer.

During an observation conducted by Inspector #699 on an identified date and time, resident #005 was observed to be unattended and asleep in an identified area while still using an identified type of transfer equipment. No staff members were observed to be in the resident's room or in the hallway nearby. Inspector waited approximately ten minutes for staff to come to resident's room. Inspector approached RPN #123 and requested that they to come to resident #005's room at which point the assigned PSW #121 arrived to the resident's room to provide care. Inspector confirmed at that time with RPN #123 and PSW #121 that resident was not supposed to be left unattended and attached to the abovementioned transfer equipment.

Record review of resident #005's MDS assessment of an identified date indicated that resident required an identified level of assistance for transfer and toileting. Further review of the MDS assessment indicated that resident #005's cognitive skills for decision making was at an identified level of impairment.

Record review of resident #005's written care plan revealed that resident requires two staff total assistance using an identified transfer equipment that was different from the equipment that was observed to be used with the resident.

In an interview with PSW #121, they revealed that resident #005 requires an identified level of assistance and care. The PSW stated that they use the transfer equipment identified on the resident's written plan of care to transfer resident from bed to chair, and a different identified transfer equipment to transfer the resident to the toilet. PSW #121 revealed that they did not refer to the care plan for the resident's transferring needs. Upon reviewing the resident's written care plan with the inspector, PSW #121 confirmed that resident #005 was to be transferred

using only the identified type of transfer equipment on the written plan of care for all transfers and that they used the incorrect lift during care on the abovementioned identified date.

In an interview with RPN #123, they also stated that they use the transfer equipment identified on the resident's written plan of care to transfer resident from bed to chair, and a different identified transfer equipment to transfer the resident to the toilet. RPN #123 revealed that they have not seen the care plan for the resident. After review of the care plan, RPN #123 acknowledged that the resident was required to only use one type of transfer equipment for all transfers as per their written plan of care. RPN #123 confirmed that resident #005's care set out in the plan of care was not provided to the resident as specified in the plan on the abovementioned identified date.

In an interview with DOC #109, stated that if the written care plan identified transfer equipment was to be used for all transfers for resident #005, then only that transfer equipment should be used. They confirmed that care set out in resident #005's plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

The Ministry of Health and Long-Term Care (MOHLTC) received complaints on an identified date regarding concerns related to high temperature levels in the home for residents #012 and #013. Review of the complaints revealed that the family members had concerns that on a number of identified dates, temperatures in the home were as high as 30 degrees (C) and that the cooling system in the home was not adequate enough to keep the facility cool.

According to O. Reg. 79/10, s. 20 (1), every licensee of a long term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents, is developed in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat.

Record review of the Heat Contingency protocol, policy #VII-G-10.10(a) revised November 2015, revealed that hot weather protocols are implemented at the onset of summer. The three type of alerts that are listed under the protocol are Summertime Practices, Intervention Alert and Emergency Alert. Further review of the policy indicated that to initiate a specific heat alert, the indoor air temperature and humidity levels in the home were required to determine the threshold. Review

of the policy revealed that maintenance staff's responsibility included recording indoor temperature and humidity percentage from various locations within the building daily and document on the Air temperature log. Maintenance staff are to inform all departments of the Heat Contingency protocols to be implemented.

Review of Air temperature logs from a two-month period covering the identified dates indicated that no humidity percentages were recorded. Further review of the air temperature logs revealed that on a weekend identified by the complainants, no temperature or humidity percentages were recorded.

In an interview with the ESM #133, they stated that their part-time staff did not record the temperature and humidity levels during the abovementioned identified weekends. ESM #133 confirmed it has not been their practice to record humidity percentages as per policy.

Interview with Executive Director (ED) #141, stated that according to the home's policy, the temperature and humidity percentages should be recorded daily. ED #133 confirmed that the Heat Contingency protocol policy was not followed. [s. 8. (1)]

2. During the initial tour of the home on an identified date and time, Inspector #565 observed the following doors leading to balconies were not locked and there was no staff in close proximity supervising the areas:
- The balcony door across from an identified area was closed but not locked, and
- The balcony door inside another identified area was closed but not locked.

In accordance with O. Reg 79/10, s. 9 (2) the licensee shall ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Review of the home's policy titled Outside Area Security, policy #VII-H-10.10, current revision date of January 2015, revealed the registered staff will ensure that all doors leading to secure outside areas; i.e. balconies, patios, and terraces are kept locked at specified times.

Subsequent observations indicated the abovementioned balcony door on the second floor was locked. Further observations indicated the following balcony doors were not locked and there were no staff in close proximity supervising the

areas:

- On July 25, 2018, at 1405 hrs, inspector #699 observed the balcony door across from another identified area was not locked.
- On July 26, 2018, at 1213 and 1305 hrs, and July 30, 2018, at 1600 hrs, inspector #565 observed the balcony door inside another identified area was not locked.

Observations and interviews with RPN #110 on July 25 and 26, 2018, confirmed the abovementioned two balcony doors were not locked. RPN #110 further stated when no program was in progress, the balcony doors should be locked to restrict unsupervised resident access.

Interview with the ESM and DOC indicated the specified times for the home to have the balcony doors kept locked at all times unless programs were in progress. The staff members confirmed as there were no programs in progress on the balcony and the door was not locked, the home's policy and protocol were not complied with. [s. 8. (1)]

3. During stage one of the RQI, resident observations on July 19 and 23, 2018, revealed lingering odour in an identified resident's room.

In accordance with LTCHA 2007, c. 8, s.15 (1) (a), every licensee of a long-term care home shall ensure that, there is an organized program of housekeeping for the home.

Review of the home's policy titled Odour Neutralizers - Housekeeping, policy #XII-G-10.30, current revision date of January 2015, revealed housekeeping staff will notify the supervisor of any area in the building which may require an assessment for the use of odour neutralizing agents.

Further observations indicated lingering urine odour in the following rooms:
- On July 25 and 26, 2018, at approximately 1112 hrs and 1232 hrs respectively, inspector #565 identified a lingering odour in the abovementioned room,
- On July 26, 27, and 30, 2018, multiple observations conducted by inspector #699 and #565 indicated lingering urine odour in another identified resident's room.

Interview with resident #004 indicated they noticed the lingering odour in the first identified room for several months and it was strong at times.

Interview with Housekeeping Staff (HS) #128 indicated they were aware of the lingering odour in the first identified room, and stated the odour was on and off for approximately a month or more. The staff member indicated they thought the nurse was aware of this and they did not report the odour to their supervisor, and just cleaned the room routinely.

Interview with HS #132 indicated they were aware of the lingering urine odour in the second identified room, and stated the odour was strong at times but doesn't go away. The staff member stated the lingering odour had been there for almost a year, and they had reported it to the former Housekeeping and Laundry Supervisor but did not recall when it was. The staff member further stated they did report the lingering odour to their current supervisor.

Interview with Housekeeping and Laundry Supervisor (HLS) #101 and the ESM indicated housekeeping staff should report to them when they identify lingering odour in the building. If the odour cannot be eliminated by housekeeping and is unrelated to nursing, the HLS will report it to the ESM to address the odour. HLS #101 and the ESM confirmed the housekeeping staff did not report the odour to their supervisor as required by the home's policy. [s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with, to be implemented voluntarily.***

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**
**Specifically failed to comply with the following:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that, where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

This inspection was initiated for resident #007 related to potential side rail restraint from the resident observation during stage one of the Resident Quality Inspection (RQI); identified side rails were observed to be in use while when the resident was in bed.

Review of the resident's current care plan in a binder at the nursing station on an identified date indicated that for bed safety, the resident was to use identified side rails to support specified routine activities of daily living, and to keep their identified type of mattress in place for safety. Staff were also to apply side rails when the resident is in bed.

Review of the home's policy titled Bed Entrapment Prevention, policy #VII-E-10.30, current revision April 2018, indicated:
- The DOC or designate will collaborate with Environmental Services to develop corrective actions to reduce the risk of bed entrapment.
- The ESM or designate will assess the bed system using the Bed Safety Entrapment Kit for identified instances, including a change in physical or clinical condition increasing the risk of entrapment, and a bed entrapment incident.

Review of resident #007's Bed System Measurement Test on an identified date showed that zones 1, 2, 3, 4, and 7 were passed with the resident's current identified type of mattress. Review of the resident #007's assessment history in pointclickcare (PCC) and environmental service records indicated that no bed safety assessments were done for resident #007 for over three years.

A Bed Safety Assessment conducted after the three-year period, by RPN #118 and the PT assessed and passed Zone 7 of the resident's bed, as the assessment detailed that bed rails were not required for the resident.

Review of progress notes and documentation on the Point of Care (POC) documentation for bed mobility showed that on four different occasions in the identified month that the most recent Bed Safety Assessment was conducted, identified parts of resident #007's body were caught in the rails; the resident was repositioned, and no injuries were noted.

Interview with RN #114 who assessed the resident on three of the four dates after PSWs informed the RN that the resident's identified parts of the body were caught, stated that the resident needed staff to release and reposition the resident, but the RN was unable to recall how they were caught. No other documentation or assessment was available other than what was documented in the progress notes. RN #114 further stated that they did not inform the PT or any other staff or managers, as the information was documented on PCC and captured by MDS. They did not do any other referrals as the resident did not sustain any injuries as a result of the bed entrapment.

Interview with RPN #118 and the PT, both of whom completed resident #007's most recent Bed Safety Assessment stated the Bed Safety Assessment was not conducted in response to resident's identified part of the body having been caught in the rails, but was done as part of a home-wide initiative for all residents. RPN #118 and the PT further stated that they were not aware of resident #007 having had their identified part of the body caught in the rails while they were in bed.

Interview with the ESM showed that they were not informed that resident #007's identified parts of the body had been caught in the rails and did not have any other records for assessment resident's bed safety since three years ago.

Interview with the DOC and the PT also stated that it was the home's process to

refer to the PT when a resident's body parts were caught in the bed rails, and that this assessment was not done for resident #007.

The DOC further stated that, for resident #007 who uses bed rails, during the four times where resident #007's identified parts of the body were caught in the rails while the resident was in bed, steps were not taken to prevent entrapment, and no assessment was done that took into consideration all potential zones of entrapment. [s. 15. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.***

---

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

(A2)
1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The inspection was initiated for resident #005 in stage two of the RQI related to an identified area of altered skin integrity.

During an observation conducted by Inspector #699 on an identified date, resident

#005 was observed to be unattended and asleep in an identified area while attached to an identified transfer equipment. No staff was observed to be in the resident's room or in the hallway nearby. Inspector waited approximately ten minutes for staff to come to resident's room. Inspector approached RPN #123 and requested that they come to resident #005's room, at which point the assigned PSW #121 arrived to the resident's room to provide care. Inspector confirmed at that time with RPN #123 and PSW #121 that resident was not supposed to be left attached to the abovementioned transfer equipment and left unattended.

Record review of resident #005's MDS assessment on an identified date indicated that resident was at an identified level of dependence and required an identified level of assistance for transfers and toileting. Further review of the MDS assessment indicated that resident #005 was at an identified level of impairment for their cognitive skills for decision making.

Record review of resident #005's written care plan revealed that resident requires two staff total assistance using an identified transfer equipment for all transfers, and this transfer equipment was different from the transfer equipment that was observed to be used on the abovementioned date.

In an interview PSW #120, they stated that residents are not to be left unattended while attached to a transfer equipment as it is not safe transferring. PSW #120 stated the transfer equipment should be removed after the resident has been transferred according to how they have been trained.

In an interview, PSW #121, indicated that resident #005 requires an identified level of assistance and care. PSW #121 indicated that they left the resident attached to the identified transfer equipment for safety. PSW #121 stated they were not taught this in training and it was their own practice to make sure the resident did not fall off the toilet. PSW #121 stated that the residents that are attached to the transfer equipment are not to be left unattended. PSW #121 confirmed that resident #005 was not transferred safely onto the toilet.

In an interview with RPN #123, stated that residents that are attached to identified transfer equipment are not be left unattended and that staff have been told this several times. RPN #123 stated that residents that use the observed identified transfer equipment need to be able follow directions and have the ability to weight bear. RPN #123 stated the resident #005 is unable to follow directions and

required a different identified transfer equipment for all care. RPN #123 confirmed that resident #005 was not safely transferred onto the toilet.

Record review of the Mechanical Lifting and Sling Safety protocol, policy #VII-G-20.20(c) revised August 2015, indicates residents that are assessed for use of mechanical lifts cannot use alternate lifting procedures.

In an interview with DOC #109, they confirmed that a resident should never be left unattended when attached to identified transfer equipment or to use the observed transfer equipment if the resident is indicated to use the other type of transfer equipment as per their care plan. DOC #109 confirmed that resident #005 was not transferred safely onto the toilet. [s. 36.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting resident, to be implemented voluntarily.***

---

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

(A2)
1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage two of the RQI resident #005 was identified through a census review and staff interview as having an identified area of altered skin integrity.

Review of the Skin and Wound Care Management Protocol, policy #VII-G-10.80, last revised July 2015, included direction for registered staff to assess residents with altered skin integrity at least weekly.

Record review of resident #005's progress notes revealed a referral to registered dietitian (RD) on an identified date for a recurring identified area of altered skin integrity. The progress note revealed that interventions had been implemented based on the assessment of the problem.

Record review of resident #005's physician's order indicated wound care orders for the identified area of altered skin integrity initiated on an identified date, which stated that the area should be cleansed with identified medication and dressing at an identified interval of time and as needed.

Record review of resident #005's skin and wound assessments on a later date indicated assessments for the identified area of altered skin integrity was initiated. Further review of assessments revealed resident had not received skin and wound assessments for their identified area of altered skin integrity on two identified dates.

Interview with RPN #135 stated that resident has an identified area of altered skin integrity on an identified part of their body. RPN #135 stated that for any resident noted with an area of altered skin integrity, it is the expectation that the registered staff should complete a skin and wound assessment. RPN #135 confirmed that a skin and wound assessment should have been completed at the time of the RD referral on the identified date, and that the initial skin and wound assessment was missed. RPN #135 confirmed that on another identified week, resident #005 did not have a skin and wound assessment completed.

Interview with DOC #109, confirmed that residents exhibiting skin breakdown require weekly wound assessments. DOC #109 further stated that it if a resident is referred to RD with an identified area of altered skin integrity, there should be a skin and wound assessment completed with the referral. [s. 50. (2) (b) (iv)]

2. As a result of non-compliance found for resident #005 related to altered skin integrity, the resident sample was expanded to include resident #014.

Record review of resident #014's MDS assessment on an identified date indicated that resident #014 had an identified area of altered skin integrity.

Record review of resident #014's weekly skin and wound assessment on another identified date indicated that resident had an identified area of altered skin integrity. Further review of resident #014's weekly assessments revealed no skin and wound assessments completed for a 20-day period.

Interview with RN #144 indicated that weekly wound assessments are required for residents with skin breakdown. RN #144 stated that if the assessments are not in PCC, then the assessments were not completed. RN #144 confirmed the skin and wound assessments for the identified 20-day period was not completed.

Interview with DOC #109, confirmed that weekly wound assessments were not completed for resident #014 during the identified 20-day period. [s. 50. (2) (b) (iv)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.***

---

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Specifically failed to comply with the following:**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that doors leading to non-residential areas were locked when they were not supervised by a staff.

During the initial tour of the RQI, an inspector observed the doors leading to the following soiled utility rooms were equipped with push-button lock, closed, but not locked. There was no staff in close proximity supervising the areas:
- Soiled utility room across from an identified resident's room, and
- Soiled utility room across from another identified resident's room.

Further observations of these two soiled utility rooms indicated their doors were not locked and there was no staff in close proximity supervising the areas as follows:
- Soiled utility room across from the first identified room on two separate dates
- Soiled utility room across from second identified room on two separate dates

Interviews and observation with PSW #126 and Housekeeping Staff (HS) #127 on an identified date indicated the door of the soiled utility room across from the first identified room was not locked as required. The strike plate on the door frame was filled with paper blocking the door from locking. PSW #126 stated they were unaware that the paper was blocking the door from locking. HS #127 stated they thought the paper was there because the door lock was not functioning but they did not know who put the paper there.

Interview and observation with PSW #125 on an identified date indicated the door of the soiled utility room across from the second identified room was not locked as required. During the observation, PSW #125 made several attempts to lock the door but the lock didn't work. The PSW indicated they were unaware that the door lock was not functioning and they will send a work order to maintenance to fix the door lock.

Interview with the ESM indicated the soiled utility rooms should not be accessible to residents and their doors should be locked at all times when not in use or supervised by staff. The ESM acknowledged the above mentioned soiled utility rooms were not locked, as required when they were not supervised by staff. [s. 9. (1) 2.]

---

**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During stage one of the RQI, resident observations revealed the following:
- On an identified date, in an identified resident's bathroom, the toilet paper holder was broken. One side of the toilet paper holder was missing and leaving a hole in the wall. The other side of the holder was loosely attached onto the wall.
- On two identified dates in an identified resident's bathroom, the vanity front facing panel was broken and not securely attached onto the vanity top, leaving the top sharp edge exposed.

Subsequent observations on an identified date indicated the abovementioned disrepairs remained unchanged.

Interviews with PSW #124 and HS #128 indicated they were not aware that the vanity was broken in the second identified room. HS #128 further stated the toilet paper holder in the first identified room had been broken for a few months, and PSW #124 indicated they had been putting toilet paper on the vanity top near the sink.

Interview with resident #004 indicated they were aware that the front facing vanity panel in an identified resident's bathroom was broken for about a few weeks and they did not know if any staff were aware of this.

Review of the home's work order records with the ESM indicated the above mentioned disrepair in another identified resident's room was reported to maintenance on an identified date after it was brought to the staff attention in staff interviews. The work order was closed the next day after a new toilet paper holder was installed.

Observation and interview with the ESM indicated in the second identified resident's bathroom, two holes on the wall left by the old toilet paper holder were patched and not painted. The vanity panel in the first identified resident's room was not repaired. The ESM confirmed the above mentioned furnishings should be fixed and maintained in a good state of repair, but they were not. [s. 15. (2) (c)]

**Issued on this 23rd day of November, 2018 (A2)**

| |
|---|
| **Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs** |

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Amended Public Copy/Copie modifiée du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by IVY LAM (646) - (A2) |
| **Inspection No. / No de l'inspection :** | 2018_484646_0011 (A2) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 017950-18 (A2) |
| **Type of Inspection / Genre d'inspection :** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Nov 22, 2018(A2) |
| **Licensee / Titulaire de permis :** | 2063414 Ontario Limited as General Partner of 2063414 Investment LP<br>302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | Weston Terrace Care Community<br>2005 Lawrence Avenue West, TORONTO, ON, M9N-3V4 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Michael Bastian |

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  23rd  day of November, 2018 (A2)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :**

Amended by IVY LAM (646) - (A2)

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

**Service Area Office / Bureau régional de services :** Toronto Service Area Office