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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 24, 2018	2018_754727_0008	022982-17, 023697-17, 025773-17, 001877-18, 021339-18, 026763-18	Critical Incident System

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

JOANNA WHITE (727), JUDITH HART (513), PRAVEENA SITTAMPALAM (699)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 18, 19, 22, 23, 24, 25, 26, 29, 30, 31, November 1, 2, 5, 6, 7, 8 and 9, 2018.

During this inspection the following Critical Incident System (CIS) report intakes were inspected: Log #026763-18,CIS # 2874-000042-18, Log #021339-18, CIS #2874-000038-18 and Log #022982-17, CIS #2874-000025-17 were related to falls; Log # 001877-18,CIS #2874-00005-18 and Log # 025773-17, CIS #2874-000032-17 were related to abuse. Log #023697-17, CIS# 2874-000027-17 was inspected under the complaint inspection (CO) 2018_634513_0014.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Resident Care (DRC), Associate Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Responsive Behaviour Lead, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Director of Environmental Services, Dietary Manager, Physiotherapist, Receptionist, and residents.

During the course of the inspection, the inspectors conducted observations in resident areas, observed staff interaction with residents, observed care delivery processes including the mobility and transfer of residents, meal services, reviewed residents' health records, meeting minutes, policies and procedures and staff training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

A Critical Incident System (CIS) report, was submitted to the Ministry of Health and Long-Term Care (MOHLTC), related to resident to resident abuse.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, (a) any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Review of resident #003's health records indicated an admission to the home in 2017 with a specified diagnosis, moderately impaired decision making ability and identified responsive behaviours. The home had identified and implemented interventions to help manage the behaviours.

Review of resident #003's progress notes along with staff interviews revealed that resident #003 had exhibited the above mentioned responsive behaviour including sexual behaviours with three different residents over a period of ten weeks. Interviews with identified staff members indicated that resident #003's responsive behaviours towards an identified resident on an identified date was abusive.

Interview with the Director of Care (DOC), Assistant Director of Care (ADOC), and Executive Director (ED) confirmed the above mentioned incidents had occurred.

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 the long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours where possible.

A CIS reportwas submitted to the MOHLTC related to resident to resident abuse.

The home's policy on Responsive Behaviour Management's VII-F-10.20, version October 2016 defined responsive behaviours as a means by which a person living with dementia or other condition may communicate their discomfort with something else related to their physical body, the physical environment, or the social environment. The person living with dementia may experience an unmet need and be unable to express themselves. Responses may be manifested by physically protective behaviours (both aggressive and

non-aggresive); and, or verbally protective behaviour (both aggressive and non-aggressive.

Resident #003's was admitted to the home in 2017, with a specified diagnosis, cognitive impairment and identified responsive behaviours. Review of the resident's care plan identified that the resident's whereabouts were to be monitored frequently; however there was no time frequency specified in the residents care plan.

Resident #003's progress notes identified nine different entries where the resident entered other residents' rooms and exhibited responsive behaviours towards identified residents. This home's policy indicated that if the responsive behaviour was endangering others, there were certain actions required; and a referral to the Responsive Behaviour Committee (RBC).

A review of the resident's clinical record including progress notes and paper record indicated the home did not complete a responsive behaviour referral as per their policy in response to resident's #003's identified episodes of responsive behaviours mentioned above.

The Responsive Behaviour Lead at the home, confirmed that resident #003 exhibited responsive behaviours and should have been referred and managed by the Responsive Behaviour Committee.

The ADOC confirmed that behavioural triggers were not identified for resident #003 and strategies were not developed and implemented to respond to resident #003's responsive behaviours.

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, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #3: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

A CIS report was submitted to the MOHLTC related to a resident fall.

Resident #002 sustained injuries and was hospitalized after the fall. The resident returned to the home approximately one week later. The resident was cognitively impaired.

Progress notes on a specified date identified that resident #002 remained at high risk for falls and required two person transfer.

Resident #002's care plan provided specific instructions regarding treatment of the injury sustained due to the fall, however the resident was non compliant with the treatment.

Separate interviews with personal support worker (PSW) #102, registered practical nurse (RPN) #101 and physiotherapist #103 confirmed the specific instructions that were identified on the care plan. All three staff confirmed the resident was not following the treatment identified in the care plan.

Observations by inspector #727 on specific dates revealed that resident #002 was not compliant with the treatment for the injury sustained due to the fall, and indicated in the resident's care plan.

Physiotherapist #103 acknowledged that the care plan needed to be updated.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A CIS report was submitted to the MOHLTC reporting resident to resident abuse.

Review of resident #003's health records indicated an admission to the home in 2017 with a specified diagnosis, moderately impaired decision making ability and identified responsive behaviours. The home had identified and implemented interventions to help manage the behaviours.

Resident #003's care plan on a specified date, indicated sexual behaviour towards other residents. The home had identified and implemented interventions to help manage the behaviours.

Progress notes on an identified date reported resident #003 was found laying on top of an identified resident.

The home's policy on Prevention of Abuse & Neglect of a Resident identified that the police are to be immediately notified of any alleged, suspected, or witnessed incident or abuse or neglect of a resident which may constitute a criminal offence.

Interviews with PSW #118 and RPN #117 acknowledged the abuse of resident #005 by resident #003.

Interview with the ED and Director of Care reported the leadership team at the home had discussed this incident and determined it was not abuse. As a result police notification and investigation were not conducted.

Issued on this 20th day of January, 2019

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

Original report signed by the inspector.