**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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## Public Copy/Copie 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 |
|---|---|---|---|
| Jun 13, 2019 | 2019_776613_0017 | 007120-17, 027789-17, 000223-18, 001292-18, 003480-18, 005803-18, 010504-18, 011268-18, 020280-18, 020331-18, 021020-18, 021025-18, 024411-18, 030739-18, 031258-18, 032355-18, 032827-18, 033353-18, 003074-19, 006127-19, 007518-19, 008227-19 | 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

LISA MOORE (613), SHELLEY MURPHY (684), SYLVIE BYRNES (627), TIFFANY BOUCHER (543)

## 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): May 27 - 31, 2019.**

**The following intakes were inspected during this Inspection:**

**Fourteen Critical Incident reports related to falls resulting in an injury;**

**Three Critical Incident reports related to improper care;**

**Three Critical Incident reports related to resident to resident sexual abuse;**

**One Critical Incident report related to resident to resident physical abuse; and,**

**One Critical Incident report related to staff to resident neglect.**

**A concurrent Complaint Inspection #2019_776613_0016, was also conducted during this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Regional Director of Operations (RDO), Executive Director (ED), Acting Director of Care (Acting DOC), Assistant Director of Cares (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.**

**The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records,internal investigation files, human resource files and policies, procedures and programs.**

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

**Falls Prevention**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**

**6 WN(s)**
**4 VPC(s)**
**1 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>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 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 :**

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

Inspector #613 reviewed a Critical Incident (CI) report submitted to the Director, identifying PSW #113 reported to RPN #116 that resident #012 sustained an injury during a transfer. The CI report indicated that RPN #116 completed an assessment on the resident and noted an altered skin integrity on their extremity. RPN #116 notified the physician and orders were received to transfer resident #012 to the hospital for further assessment.

A review of the licensee's policy titled, "Resident Transfer & Lift Procedures" (#: VII-G-20.20) last revised April 2018, identified that the PSW would lift/transfer resident according to plan of care and use transfer and repositioning aids according to plan of care.

A review of the licensee's policy, at the time of the incident, titled, "Plan of Care" (#: VII-C-10.90) last revised April 2018, identified that the PSW would provide care as specified in the resident's plan of care.

A review of the licensee's protocol titled, "Mechanical Lifting & Sling Safety Protocol" (#: VII-G-20.30 (l), identified that if a resident was assessed for a mechanical lift, under no circumstances shall an alternative lifting procedure be used and when a mechanical lift is utilized, two team members were required to perform the function. At no time was it permissible for only one team member to operate a mechanical lift.

A review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS), at the time of the incident, identified that resident #012 required total dependence of two staff members, using a specific type of transfer.

A review of resident #012's care plan, at the time of the incident, identified that they required two staff members using a specific type of transfer and a specific device.

The Inspector reviewed the home's internal investigation file, which revealed that PSW #113 had transferred resident #012 alone from their mobility aid to their bed, without using a specific type of transfer. PSW #113 received discipline for their failure to follow resident #012's care plan and the Resident Transfer & Lift Procedures policy.

During an interview with Assistant Director of Care (ADOC) #100, they verified that PSW#113 did not use safe transferring techniques when transferring resident #012 from their mobility aid to the bed and did not follow the home's policy for safe resident transfers and lift procedures. [s. 36.]

2. Inspector #613 reviewed a Critical Incident (CI) report submitted to the Director, identifying PSW #115 and PSW #116 were assisting resident #014 from their mobility aid into bed with a specific type of transfer. During the transfer process, the resident was noted by both PSWs to be leaning and sliding out of the specific device; therefore, the PSWs lowered the resident to the floor, as a result the resident sustained an area of altered skin integrity.

A review of the licensee's policy titled, "Resident Transfer & Lift Procedures" (#: VII-G-20.20) last revised April 2018, identified that the PSW would check prior to moving a resident that the equipment was functioning and correct positioning of the equipment.

A review of the licensee's protocol titled, "Mechanical Lifting & Sling Safety Protocol" (#: VII-G-20.30 (l), identified that team members must complete a visual check of each lift and sling prior to use and must check that the appropriate sling was utilized for the lift and that the lifts are fitted safely over the appropriate crossbars and check that the loops of slings do not pose a safety risk to any residents. The manufacturer's instructions should be followed for safe operation of the lift.

A review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS), at the time of the incident, identified that resident #014 required total dependence of two staff members assisting with a specific type of transfer.

A review of the resident #014's care plan, at the time of the incident, identified that they required two staff members assisting with a specific type of transfer and a specific

device.

The Inspector reviewed the home’s internal investigation file, which revealed that PSW #115 and PSW #116 had not checked the resident to ensure the specific device was applied properly before initiating the transfer and did not ensure that the specific device was fully tucked in correctly under the resident before initiating the transfer, resulting in the resident sliding out of the specific device and resulting in an injury. PSW #115 and PSW #116 received discipline for their failure to follow the Resident Transfer & Lift Procedures policy and the Mechanical Lifting & Sling Safety Protocol.

During an interview with Assistant Director of Care (ADOC) #100, they verified that PSW#115 and PSW #116 did not use safe transferring techniques when transferring resident #014 from their mobility aid to the bed and did not follow the home’s policy for safe resident transfers and lift procedures. [s. 36.]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.***

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**WN #2: 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 has 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 changed or care set out in the plan was no longer necessary.

Inspector #684 reviewed a CI report that was submitted to the Director, for an incident that caused an injury to resident #015.

A review of resident #015's care plan, under the foci for falls, identified an intervention, requiring staff to put a safety device on the resident, when resident #015 was in their mobility aid or in bed.

The Inspector observed resident #015 sitting in their mobility aid without a safety device in place. Inspector #684 asked resident #015 if they had a safety device while up in their mobility aid, to which the resident responded “no”.

A review of the licensee’s policy “Documentation-Plan of Care" ( VII-C-10.90), last revised in April 2018, indicated the following under the procedure section: reassess and update the care set out in the plan of care as required if the care was no longer necessary or it had not been effective; consider different approaches in the revision of the plan of care.

During an interview with PSW #121, they stated that resident #015 did not have a safety device; at one time they did, but it had been discontinued.

During an interview with RN #117, they stated that resident #015 was independent and did have a safety device on their mobility aid.

During an interview with ADOC #100, the Inspector and ADOC reviewed resident #015's care plan. The ADOC verified that the resident's care plan required updating related to the focus of fall prevention. Specifically looking at the intervention of putting the safety device on when resident #015 was in their mobility aid or bed, as the resident no longer required this intervention. [s. 6. (10) (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 resident is 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, to be implemented voluntarily.***

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**WN #3: 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

In accordance with O. Reg. 79/10, s. 49 (2), the licensee was required to ensure that when a resident had fallen, the resident was assessed.

Specifically, staff did not comply with the licensee's policy regarding "Falls Prevention", (VII-G-30.00) revised January 2015, which was in place at the time of the incident, and also part of the licensee's fall prevention and management program.

Inspector #684 reviewed a CI report that was submitted to the Director on a specific date, indicating staff neglect of resident #002 by RN #103, related to not completing a post falls

assessment regarding a fall that had occurred on an earlier date. The licensee had submitted an additional CI report related to the fall of resident #002 on the earlier date. The second CI report submitted on a specific date, identified that resident #002 was noted to have a swelling, bruising to specific body areas and symptoms of discomfort when they were repositioned on an earlier date. Within the CI report ADOC #100 wrote "Current finding indicated that charge nurse #103 did not complete the necessary assessment”.

A review of the Fact Finding notes, dated on a specific date, in which RN #103 was in attendance, identified that RN #103 completed an assessment of resident #002 and noted swelling to a specific body area and the resident was experiencing discomfort on repositioning. The Fact Finding notes described that RN #103 had decided to wait for the nurse on the next shift to assess the resident. The Fact Finding notes indicated that RN#103 confirmed they should have sent resident to the hospital right away for further assessment and that they had not completed a pain assessment or provided analgesic to the resident for their discomfort. RN #103 received discipline for failing to follow the falls protocol, proper documentation, head to toe assessment and pain assessment for resident #002.

A review of resident # 002's progress notes, dated on a specific date, identified that resident #002 had two areas of discolouration to their skin, an area of swelling and they were expressing discomfort when they were turned and touched on a specific body area. It was documented that RN #103 would have the nurse on the next shift follow up.

During an Interview with RN #117, they stated that a resident would be sent to the hospital for further medical assessment, if a RN suspected a fracture or if a resident was exhibiting severe pain.

During an interview with ADOC #101, they stated that according to the home's policy, RN #103 should have assessed resident #002 and contacted the physician for an order for x-ray or sent resident #002 to the hospital for further assessment. [s. 8. (1) (a),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 the Falls Prevention policy is complied with, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

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

**s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that the abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director.

Inspector #684 reviewed a CI report that was submitted to the Director on a specific date, indicating staff neglect of resident #002 by RN #103, related to not completing a post falls assessment regarding a fall that had occurred on an earlier date. The licensee had submitted an additional CI report related to the fall of resident #002 on the earlier date.

The second CI report submitted on a specific date, identified that resident #002 was noted to have a swelling, bruising to specific body areas and symptoms of discomfort when they were repositioned on an earlier date. Within the CI report ADOC #100 wrote "Current finding indicated that charge nurse #103 did not complete the necessary assessment".

A review of resident # 002's progress notes, dated on a specific date, identified that resident #002 had two areas of discolouration to their skin, an area of swelling and they were expressing discomfort when they were turned and touched on a specific body area. It was documented that RN #103 would have the nurse on the next shift follow up. A second note dated on a specific time and date, identified that the writer had received report from the out-going shift regarding resident #002's condition and completed an assessment, which identified that the resident had bruising and swelling to specific body areas.

A review of the Fact Finding notes, dated on a specific date, in which RN #103 was in attendance, identified that RN #103 completed an assessment of resident #002 and noted swelling to a specific body area and the resident was experiencing discomfort on repositioning. The Fact Finding notes described that RN #103 had decided to wait for the nurse on the next shift to assess the resident. The Fact Finding notes indicated that RN#103 confirmed they should have sent resident to the hospital right away for further assessment and that they had not completed a pain assessment or provided analgesic to the resident for their discomfort. RN #103 received discipline for failing to follow the falls protocol, proper documentation, head to toe assessment and pain assessment for resident #002.

A review of the licensee's policy "MOHLTC- Duty to Report", Policy # XXIII-C-10.80. Which indicated under the Policy section: "As set out in Section 24 of the Long Term Care Act 2007, a person who has reasonable grounds to suspect that any of the following reportable matters listed below has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the MOHLTC Director. In addition, this same information must be reported to the Executive Director/Administrator or designate so that an investigation can be started immediately. Reportable matters under section 24 include: Any incident with respect to alleged, suspected, or witnessed abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

During an interview with ADOC #100, they confirmed that the homes abuse and neglect

policy stated that it is to be reported immediately, even if it is suspected. [s. 24. (1)]

2. Inspector #543 reviewed a CI report that was submitted to the Director, related to an alleged incident of abuse resident to resident sexual abuse involving resident #010 and #011.

During an interview with RN #109, they indicated that they were required to immediately inform their supervisor of any alleged or witnessed incident of abuse. They stated that it was their supervisor or manager who were responsible of investigating and reporting incidents to the Director.

During an interview with ADOC #100, they indicated that any alleged abuse needed to be reported to the Director immediately. The ADOC verified that this incident was not reported immediately as required. [s. 24. (1)]

3. Inspector #613 reviewed a CI report that was submitted to the Director, identifying that resident #004 and #005 had an altercation in a home area, where resident #005 threw an object at resident #004, missing them and in response resident #004 threw an object at resident #005 that struck them, resulting in an injury. As identified on the CI report, the incident occurred on a specific date, but was not reported to the Director until one day later.

A review of the licensee's policy titled, "MOHLTC – Duty to Report" last revised August 2018, identified that as set out in Section 24 of the Long Term Care Act 2007, a person who has reasonable grounds to suspect that any incident with respect to alleged, suspected, or witnessed abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it was based to the MOHLTC Director.

During an interview with ADOC #101, they confirmed that the CI report had been reported late. ADOC #101 stated that the former ADOC, who was no longer an employee at the home, did not report the CI immediately. ADOC #101 further stated that it was the responsibility of the ADOC or DOC to submit the CI report to the Director; however, any registered staff may call the Director After-Hour's line. [s. 24. (1)]

***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 a person who has reasonable grounds to suspect that the abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement**

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

**s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a PASD (Personal Assistance Services Device) described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's care plan.

The LTCHA 2007, c. 8, s. 33 (2) indicates that a PASD means personal assistance services device, being a device used to assist a person with a routine activity of living.

Inspector #627 reviewed a CI report that was submitted to the Director, regarding a fall of resident #017, that resulted in an injury.

During an observation, resident #017 was observed in their room, sitting in a mobility aid positioned in a certain way with a specific device in place.

A review of resident #017's care plan, did not indicate any directives regarding resident #017 being positioned in a certain way during specific aspects of care or the use of a

specific device.

A review of the licensee's policy titled "Personal Assistance Services Devices" last revised April 2019, indicated that "a Personal Assistance Services Devices (PASD) could only be used if its use was included in the resident's plan of care and all of the following conditions were met:

-Alternatives to the use of the PASD had been considered, and tried where appropriate, but would not be or has not been effective to assist the resident with the routine activity of living.
-The use of the PASD was reasonable, given the resident's physical and mental condition and personal history, and was the least restrictive PASD that would be effective to assist the resident.
- A physician, nurse, occupational therapist, or physiotherapist had approved the use of the PASD.
- The resident or, if the resident was incapable, the resident's substitute decision-maker, had consented to the use of the PASD.
- The resident's plan of care provided for any other requirements set out in the Regulation.
-PASD was considered a restraint when it had the effect of limiting or inhibiting a resident's freedom of movement and the resident was not able, either physically or cognitively, release themselves from the PASD. If a device that limits or inhibits freedom of movement [was] being used to restrain a resident rather than to assist the resident with a routine activity of living, then the requirements relating to restraining by physical device apply.

During an interview with PSW #107, they stated that the care plan guided staff to the care a resident was to receive. They stated that resident #017 was positioned in a certain way with a specific device in place while in their mobility aid for comfort measure, which was a PASD. PSW #107 acknowledged that there was no focus for a PASD, or interventions for resident #017 being positioned in a certain way during specific aspects of care or the use of a specific device, in their care plan.

During an interview with RN #109, they stated that when a PASD was utilized, it was to be identified in the resident's care plan. RN #109 further stated that resident # 017 was not to be positioned in a certain way during specific aspects of care with a specific device, as the resident had never been assessed for a PASD.

During an interview with ADOC #100, they stated that when a resident utilized a PASD, it was to be added to their care plan. The ADOC acknowledged that resident #017 should not have been positioned in a certain way while in their mobility aid. [s. 33. (3)]

***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 when a PASD is used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's care plan, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

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

**s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident were promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who were to be notified.

Inspector #627 reviewed a CI report that was submitted to the Director, regarding a fall of resident #017, that resulted in an injury. The CI report indicated that the Charge Nurse (RPN #127) had not informed the resident's SDM about a fall.

A review of the licensee's policy titled "Change of Status- Notification of POA/Family", (#VIII-B-10.20), last revised January 2015, indicated that a resident's SDM was to be notified when a resident had a significant health status change, and was transferred to the hospital.

A review of resident #017's progress notes, identified a progress note documented by RN #118, which indicated that they had called resident #017's SDM, 42.5 hours after resident #017's fall and had apologized to them that they were not informed right away of the fall incident.

During an interview with RN #109, they stated that resident #017's SDM should have been notified immediately when the resident fell.

During an interview with the Acting DOC, they acknowledged that RPN #127 had not notified resident #017's SDM of the fall for which RPN #127 had received disciplinary action. [s. 107. (5)]

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**Issued on this 14th day of June, 2019**

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

**Original report signed by the inspector.**

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

**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

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

**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**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | LISA MOORE (613), SHELLEY MURPHY (684), SYLVIE BYRNES (627), TIFFANY BOUCHER (543) |
| **Inspection No. / No de l'inspection :** | 2019_776613_0017 |
| **Log No. / No de registre :** | 007120-17, 027789-17, 000223-18, 001292-18, 003480-18, 005803-18, 010504-18, 011268-18, 020280-18, 020331-18, 021020-18, 021025-18, 024411-18, 030739-18, 031258-18, 032355-18, 032827-18, 033353-18, 003074-19, 006127-19, 007518-19, 008227-19 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jun 13, 2019 |
| **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 |

| **Ministry of Health and Long-Term Care** | **Ministère de la Santé et des Soins de longue durée** |
|---|---|
| **Order(s) of the Inspector** | **Ordre(s) de l’inspecteur** |
| Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8 | 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 |

**Name of Administrator / Nom de l’administratrice ou de l’administrateur :** Michael Bastian

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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:

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**Order # / Ordre no :** 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

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.

**Order / Ordre :**

The licensee must be compliant with r. 36 of the LTCHA.

Specifically the licensee must:

A) Ensure that all staff use safe transferring and positioning devices or techniques as directed in each residents' care plans and as per the licensee's policy titled, "Resident, Transfer & Lift Procedure" and the licensee's protocol titled, "Mechanical Lifting & Sling Safety".

**Grounds / Motifs :**

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

Inspector #613 reviewed a Critical Incident (CI) report submitted to the Director, identifying PSW #113 reported to RPN #116 that resident #012 sustained an injury during a transfer. The CI report indicated that RPN #116 completed an assessment on the resident and noted an altered skin integrity on their extremity. RPN #116 notified the physician and orders were received to transfer resident #012 to the hospital for further assessment.

A review of the licensee's policy titled, “Resident Transfer & Lift Procedures” (#: VII-G-20.20) last revised April 2018, identified that the PSW would lift/transfer resident according to plan of care and use transfer and repositioning aids according to plan of care.

A review of the licensee's policy, at the time of the incident, titled, “Plan of Care” (#: VII-C-10.90) last revised April 2018, identified that the PSW would provide

care as specified in the resident's plan of care.

A review of the licensee's protocol titled, "Mechanical Lifting & Sling Safety Protocol" (#: VII-G-20.30 (l), identified that if a resident was assessed for a mechanical lift, under no circumstances shall an alternative lifting procedure be used and when a mechanical lift is utilized, two team members were required to perform the function. At no time was it permissible for only one team member to operate a mechanical lift.

A review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS), at the time of the incident, identified that resident #012 required total dependence of two staff members, using a specific type of transfer.

A review of resident #012's care plan, at the time of the incident, identified that they required two staff members using a specific type of transfer and a specific device.

The Inspector reviewed the home's internal investigation file, which revealed that PSW #113 had transferred resident #012 alone from their mobility aid to their bed, without using a specific type of transfer. PSW #113 received discipline for their failure to follow resident #012's care plan and the Resident Transfer & Lift Procedures policy.

During an interview with Assistant Director of Care (ADOC) #100, they verified that PSW#113 did not use safe transferring techniques when transferring resident #012 from their mobility aid to the bed and did not follow the home's policy for safe resident transfers and lift procedures. [s. 36.]

2. Inspector #613 reviewed a Critical Incident (CI) report submitted to the Director, identifying PSW #115 and PSW #116 were assisting resident #014 from their mobility aid into bed with a specific type of transfer. During the transfer process, the resident was noted by both PSWs to be leaning and sliding out of the specific device; therefore, the PSWs lowered the resident to the floor, as a result the resident sustained an area of altered skin integrity.

A review of the licensee's policy titled, "Resident Transfer & Lift Procedures" (#: VII-G-20.20) last revised April 2018, identified that the PSW would check prior to

moving a resident that the equipment was functioning and correct positioning of the equipment.

A review of the licensee's protocol titled, "Mechanical Lifting & Sling Safety Protocol" (#: VII-G-20.30 (l), identified that team members must complete a visual check of each lift and sling prior to use and must check that the appropriate sling was utilized for the lift and that the lifts are fitted safely over the appropriate crossbars and check that the loops of slings do not pose a safety risk to any residents. The manufacturer's instructions should be followed for safe operation of the lift.

A review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS), at the time of the incident, identified that resident #014 required total dependence of two staff members assisting with a specific type of transfer.

A review of the resident #014's care plan, at the time of the incident, identified that they required two staff members assisting with a specific type of transfer and a specific device.

The Inspector reviewed the home's internal investigation file, which revealed that PSW #115 and PSW #116 had not checked the resident to ensure the specific device was applied properly before initiating the transfer and did not ensure that the specific device was fully tucked in correctly under the resident before initiating the transfer, resulting in the resident sliding out of the specific device and resulting in an injury. PSW #115 and PSW #116 received discipline for their failure to follow the Resident Transfer & Lift Procedures policy and the Mechanical Lifting & Sling Safety Protocol.

During an interview with Assistant Director of Care (ADOC) #100, they verified that PSW#115 and PSW #116 did not use safe transferring techniques when transferring resident #014 from their mobility aid to the bed and did not follow the home's policy for safe resident transfers and lift procedures.

The severity of this issue was determined to be a level 3 as there was actual harm and risk to the residents. The scope of the issue was a level 2 as it related to two residents reviewed. The home had a level 3 history as they had on-going non-compliance with this section of the LTCHA that included:

-Voluntary Plan of Correction (VPC) issued September 7, 2018 (2018_484646_0011);
-VPC issued February 17, 2017 (2017_370649_0002.

(613)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Jul 31, 2019

## 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

## Ordre(s) de l’inspecteur

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

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 13th day of June, 2019**

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

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

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