Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 20, 2020	2020_631210_0003	022220-19, 023128-19, 023573-19, 001670-20, 001696-20	Complaint

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

SLAVICA VUCKO (210), IANA MOLOGUINA (763)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 27, 28, 29, 30, 31, February 3, 4, 5, 6, 7, 10, 11, and 12, 2020.

The following Complaints were inspected:
-Log # 022220-19, related to skin and wound management program,
-Log #023573-19, related to personal support services,
-Log #001696-20, related to hospital transfer which resulted in a significant change in the resident's health status.

This inspection was conducted concurrently with a Critical Incident System (CIS) inspection. The following intakes were inspected:
-2874-000045-19 (Log #023128-19), related to skin and wound management program,
-2874-000005-20 (Log #001670-20), related to hospital transfer which resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of care (DOC), Assistant Director of Care (ADOC), Social Worker (SW), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physician, Personal Support Workers (PSWs), residents and family members.

During the course of the inspection, the inspector observed staff and resident interactions and the provision of care, reviewed clinical records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Skin and Wound Care

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

- **3 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. 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

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

A complaint was submitted to the Ministry of Long Term Care (MLTC) that when resident #004 was admitted to the home on a specified date, they sustained a fall on the same day of admission. The next day the resident's health status changed, they were transferred to hospital, and passed away several days later.

A review of resident #004's clinical record indicated the resident was at high risk for falls. The admission documents indicated the resident had numerous falls before the admission and at times they would fall unexpectedly.

Interview with the Social Worker (SW) indicated on the day of admission they provided a transport wheelchair from the home to the resident because they were not able to stand or walk. The SW communicated with management but not the registered staff, that the resident might be at risk for falls. The interdisciplinary team held an initial meeting with the family and learned that the resident was at high risk for falls.

Interview with PSW #105 who provided personal care on the day of admission, indicated they were not informed that the resident was at high risk for falls and that they required two person assistance for transfer and shower. The PSW noticed the family was walking the resident by one-person assistance and assumed that it would be okay to transfer and provide the shower on their own. The PSW did not know that the resident was provided a wheelchair from the home but thought that the resident came with their own wheelchair. The registered staff did not communicate this information with the PSW and they were busy with the Doctor. PSW #105 indicated they provided a shower to the resident after lunch, and transferred the resident from the wheelchair to the shower chair on their own. The PSW further indicated that the personal support actions to direct PSWs regarding the resident's care were not created in the computer, and they did not ask the nurse about the level of assistance the resident required during shower.

According to the Physiotherapist (PT) they assessed the resident and determined that the resident required two-person assistance for all transfers. They documented the assessment in the progress notes and informed the registered staff.

According to interview with PSW #109, the resident sustained a witnessed fall at a specified time in their room, when trying to stand up from the wheelchair. The PSW left the room shortly and when they came back noticed the resident standing up. The resident lost their balance and was assisted by the PSW to sit on the floor. PSW #109 stated that the resident did not hit their head. Interviews with RPN #111 and RPN #114 indicated the resident layed on three mattresses on the floor after the fall and was rolling around due to being unsettled. According to PSWs #112 and #113, when they provided toileting care in the morning at a specified time, the resident did not present with changes in their health status.

Interview with RPN #107 indicated unawareness that PSW #105 provided a shower to resident #004 on the day of admission. The RPN further indicated that the PSW did not ask them about the level of assistance when providing shower.

Interviews with RPN #107, ADOC #101 and ADOC #102 indicated that when resident #004 was provided showering it should have been done by two people according to the PT assessment. PSW #105 did not consult the registered staff or the PT about the level of care required including the transfer status of the resident when providing shower. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the designate of the resident/SDM had been given an opportunity to participate fully in the development and implementation of the plan of care.

A complaint was submitted to the MLTC on a specified date, by the Substitute Decision Maker (SDM) of resident #002 that they were not informed about the changes in the skin integrity on a specific body area of the resident.

A review of resident #002' clinical record indicated that the resident's skin on a specified body area presented with changes several months earlier. The Physician ordered a specific test, and the result was negative. One month later another test was performed and the result indicated specific changes and recommended further evaluation with a different test. A family care conference was held two months later. The Physician and SDM discussed and the SDM indicated they did not wish further investigations or interventions as per the resident's wishes. As per the progress notes, the Physician documented that the SDM requested comfort measures and no aggressive intervention as per the resident's previous wishes. According to the SDM after the care conference they took a photo of the skin area with altered skin integrity.

Further review of resident #002’s clinical record did not discover documentation about the status of the resident's skin changes for a period of approximately two months after the care conference. According to the progress notes, on a specified date the SDM noted swelling on one body area and informed the registered nurse. The Physician was informed and they ordered a specific test of the affected area. The result indicated a negative result.

According to the SDM, when they visited the resident approximately two months after the care conference, the resident was scratching the affected skin area. When they looked at the area, they discovered that the changes to the specified area were worse than the last time they saw it. They reported it to registered staff. According to the clinical record the registered staff initiated the weekly skin assessment immediately.

Interview with PSW #105 indicated that they observed the gradual changes of resident #002's specific skin area, documented in Point of Care (POC) and reported to registered staff. PSW #105 indicated that they noticed that another area on the resident's skin appeared to look the same as the previous skin area before it started to worsen. The PSW was not able to describe exactly the progress of the skin worsening, however indicated that the registered staff was informed.

Interview with RPN #107 indicated that the condition of resident #002's first specific skin area was followed by the Physician. The RPN was uncertain about the method how the specific change of the skin area was to be measured and compared to the previous status. On a specified date the skin changes were reported by the SDM, and the RPN started the weekly skin assessments. The RPN further indicated that the SDM did not agree to further interventions during the previous evaluations and they wanted comfort measures. According to the RPN, the resident's skin did not require a specific treatment.

According to the clinical record, on a specified date, resident #002 attended a specialist appointment for further investigation. The hospital report from the specialist indicated that the resident had a specific health condition and discussed with the SDM about further care. A review of the photos taken by resident #002's SDM taken approximately two and a half months apart, indicated that the specified skin area presented with changes that worsened.

According to the interview with resident #002's SDM, the photos presented by the SDM and review of the clinical record, the SDM was not informed about the changes to resident #002's specified skin area for a period of two months. Interviews with DOC, ADOC #101, and RPN #107 acknowledged that resident #002's SDM was not provided opportunity to participate in development and implementation of resident #002's plan of care. [s. 6. (5)]

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 collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, and that the designate of the resident/SDM has been given an opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing resident #006's care was held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker.

A complaint regarding resident #006's care, including their admission process, was submitted to the MLTC on a specified date. As per the complainant, resident #006 did not receive an admission care conference with the interdisciplinary team while they resided at the home.

A review of resident #006's clinical records indicated the resident was admitted to the home on a specified date, with multiple diagnoses. Resident #006 had a history of multiple falls in the community. The resident had a specific cognitive impairment and experienced a certain number of falls in the home. During the last fall the resident was hospitalized. One month later their condition deteriorated, and they passed away.

Resident #006's records were reviewed and indicated there was no documentation that an admission care conference was held with the interdisciplinary team and the resident or their substitute decision-maker during resident #006's admission at the home, or an attempt to schedule one.

During an interview, SW #110 indicated that they oversaw the scheduling of admission and annual care conferences for residents. SW #110 started scheduling conferences for

the following month around the midpoint of the current month. SW #110 began the process by reviewing the physicians' availability to attend care conferences and then called the substitute decision-makers of the residents to confirm their availability. SW #110 indicated that because the physicians' schedules had limited space for resident care conferences, the conferences were usually scheduled eight weeks after a resident's admission rather than at the six-week mark. For resident #006, SW #110 reviewed their physician's availability for attending an admission care conference; SW #110 noted that other residents on the annual care conference list were due for their annual care conferences earlier than resident #006. Therefore, SW #110 prioritized residents on the annual care conference list and scheduled their care conferences prior to resident #006. The next available date for resident #006's care conference was on a specified date, 11 weeks after their admission. SW #110 was planning to call resident #006's substitute decision-maker to confirm the date of the care conference, however resident #006 has passed away.

SW #110 confirmed that resident #006 did not receive an initial care conference during their admission at the home, and that there was no attempt to schedule an initial care conference with the resident or their substitute decision-maker because they passed away before a time slot was available to schedule the conference. [s. 27. (1)]

2. As a result of non-compliance identified for resident #006, the sample was expanded to include residents #010 and #011.

A review of resident #010's clinical records indicated they were admitted to the home on a specified date. Resident #010's progress notes indicated that an initial care conference was held with resident #010's substitute-decision maker together with the interdisciplinary team eight weeks after their admission.

Interview with SW #110 confirmed that resident #010 did not receive an initial care conference within the first six weeks of their admission. [s. 27. (1)]

3. A review of resident #011's clinical records indicated they were admitted to the home on a specified date. Resident #011's progress notes indicated that an initial care conference was held with resident #011 and their substitute-decision maker together with the interdisciplinary team 15 weeks after their admission.

Interview with SW #110 confirmed that resident #011 did not receive an initial care conference within the first six weeks of their admission.

A review of the most recent resident admissions to the home in the last six months indicated that out of the 27 residents (including resident #006) that were due for an admission care conference, only three of those residents received an admission care conference within the first six weeks of their admission.

This non-compliance was issued as a result of a care conference of the interdisciplinary team providing resident #006's care as well as 24 other residents was not held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker. [s. 27. (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 care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, to be implemented voluntarily.

WN #3: 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 :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has received 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.

According to O. Reg. 79/10, s. 50 (3), "altered skin integrity" means potential or actual disruption of epidermal or dermal tissue.

A complaint was submitted to the MLTC on a specified date, by the Substitute Decision Maker (SDM) of resident #002 that they were not informed about the changes in the skin integrity on a specific body area of the resident.

A review of resident #002's clinical record indicated that the resident's skin on a specified body area presented with changes several months earlier. The Physician ordered a specific test, and the result was negative. One month later another test was performed and the result indicated specific changes and recommended further evaluation with a different test. A family care conference was held two months later. The Physician and SDM discussed and the SDM indicated they did not wish further investigations or interventions as per the resident's wishes. As per the progress notes, the Physician documented that the SDM requested comfort measures and no aggressive intervention

as per the resident's previous wishes.

According to the SDM after the care conference they took a photo of the skin area with altered skin integrity.

Further review of resident #002's clinical record did not discover documentation about the status of the resident's skin changes for a period of approximately two months after the care conference. According to the progress notes, on a specified date the SDM noted swelling on one body area and informed the registered nurse. The Physician was informed and they ordered a specific test of the affected area. The result indicated a negative result.

According to the SDM, they visited the resident approximately two months after the care conference, and the resident was scratching the affected skin area. When they looked at the area, they discovered that the changes to the specified area were worse than the last time when they saw it. They reported it to registered staff. According to the clinical record the registered staff initiated the weekly skin assessment immediately.

Interview with PSW #105 indicated that they observed the gradual changes of resident #002's specific skin area, documented in Point of Care (POC) and reported to registered staff. PSW #105 indicated that they noticed that another area on the resident's skin appeared to look the same as the previous skin area before it started to worsen. The PSW was not able to describe exactly the progress of the skin worsening, however indicated that the registered staff was informed.

Interview with RPN #107 indicated that the condition of resident #002's specific skin area was followed by the Physician. The RPN was uncertain about the method how the specific change of the skin area was to be measured and compared with the previous status. When the skin changes were reported by the SDM on a specified date, the RPN started the weekly skin assessments. The RPN further indicated that the SDM did not agree to further interventions during the previous evaluations and they wanted comfort measures. According to the RPN, the resident's skin did not require a specific treatment.

According to the clinical record, on a specified date, resident #002 attended a specialist appointment for further investigation. The hospital report from the specialist indicated that the resident had a specific health condition and it was discussed with the SDM about further care.

A review of the photos taken by resident #002's SDM taken approximately two and a half months apart, indicated that the specified skin area presented with changes that worsened .

Interview with ADOC #101 acknowledged that the skin changes were considered as altered skin integrity.

A review of the home's policy Skin and Wound Care Management, Vii-G-10.92 dated May 2019, indicated that the Skin Care Coordinator would conduct weekly wound and skin rounds with RPN/RN in resident home area/neighbourhood, assessing pressure wounds Stage 2 or greater and wounds with other etiologies.

According to the interview with resident #002's SDM, review of the photos presented by the SDM, review of the clinical record, and interviews with DOC, ADOC #101, and RPN #107, the change in the altered skin integrity of resident #002's skin area was not assessed for a period of two months. [s. 50. (2) (b) (i)]

Issued on this 26th day of February, 2020

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

Original report signed by the inspector.