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

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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
Jul 21, 2020	2020_631210_0007	010507-20	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)

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): June 19, 22, 25, July 2, 3, 7 and 8, 2020. The inspection was conducted off-site.

During the course of the inspection, the following Complaint intake log was inspected:
Log #010507-20 related to hospitalization, change in health status, plan of care, and lost personal items.

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), Interim Director of resident programs, Physician, Registered Dietician (RD), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Personal Support Workers (PSWs) and Representative from the Mobile Imaging company.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 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. (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.

A complaint was submitted to the Ministry of Long-Term care (MLTC) that resident #001 was transferred to hospital on a specified date and passed away. The family indicated that the family believed that their loved one did not receive adequate care and medical attention during the time prior to their passing. During the period the resident's health status changed, the home was in COVID-19 outbreak, and the resident was not COVID-19 positive.

According to the family member they communicated with the resident before they were transferred to hospital, when they learned that their health condition changed.

A review of resident #001's clinical record indicated the resident was admitted to the home on a specified date and had multiple diagnoses. The resident was able to communicate and was going for external medical treatments independently.

A review of resident #001's clinical record, indicated that on a specified date a specific treatment was changed and the resident was monitored. According to the record review and interview with registered staff RPN #101 the resident's condition deteriorated further.

The RPN contacted the Physician on call and obtained a physician's order for further treatments and tests.

Interview with the Physician indicated the resident was going regularly to the external treatments and there was no further deterioration in the resident's condition for one week, but improvement.

Interview with RPN #102 indicated they monitored the resident's health condition two times during their shift on a specified date and it had deteriorated. RPN #102 indicated that the resident's condition was not within normal range, but the level of consciousness (LOC) was not changed. The RPN did not inform the RN or the Physician on call, because they considered that the condition had improved. During the interview with RPN #102 they were not able to elaborate if the health condition of the resident was assessed to be within their typical trend. Interview with RN #104 and Physician #112, indicated that the Physician on call should have been informed about resident #001's abnormal health condition.

Interview with the DOC indicated that the home was in COVID-19 outbreak during the period from April 6, until July 13, 2020, and the staff worked under pressure. The DOC further acknowledged that the health condition of resident #001 had changed according to their typical trend for that period, and the Physician was not informed. [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.

A complaint was submitted to the MLTC that resident #001 was transferred to hospital on a specified date and passed away. The family indicated that the family believed that their loved one did not receive adequate care and medical attention during the time prior to their passing. During the period the resident's health status changed, the home was in COVID-19 outbreak, and the resident was not COVID-19 positive.

According to the family member they communicated with the resident before they were transferred to hospital, when they learned that their health condition changed.

A review of resident #001's clinical record indicated the resident was admitted to the home on a specified date and had multiple diagnoses. The resident was able to communicate and was going for external medical treatments independently.

A review of resident #001's clinical record, indicated that on a specified date the resident's condition changed and the treatment was adjusted. According to the record review and interview with registered staff RPN #101, the resident's health status had deteriorated, and the resident expressed the same to the registered staff. The RPN contacted Physician #112 who was on call and obtained a physician's order for further tests.

Interview with RPN #101 indicated they faxed the test requisition to the medical service company on a specified date and time. According to RPN #101 it was not a practice to attach the print out from the fax machine as a confirmation that the requisition was faxed. Interview with the medical service company representative staff # 108 indicated that the requisition for diagnostic test of resident #001 was not received until one week later. The technician conducted the test two days after the requisition was received. The home was informed about the results after the test was performed. Interview with staff #108 did not indicate that there was interruption in services due to the COVID-19 outbreak in the home. Interview with RPN #101 indicated that two days after the specified test was ordered the test was not performed yet.

Interview with the DOC indicated that the home was in COVID-19 outbreak from April until July 2020 and the staff worked under pressure. The DOC further acknowledged that the specified test ordered on specified date for resident #001 was not conducted for one week. [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 collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, and the care set out in the plan of care was 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of special treatments and interventions.

A complaint was submitted to the MLTC that resident #001 was transferred to hospital on a specified date and passed away. The family indicated that the family believed that their loved one did not receive adequate care and medical attention during the time prior to their passing. During the period the resident's health status changed, the home was in COVID-19 outbreak, and the resident was not COVID-19 positive.

According to the family member they communicated with the resident before they were transferred to hospital, when they learned that their health condition changed.

A review of resident #001's clinical record indicated the resident was admitted to the home on a specified date and had multiple diagnoses. The resident was able to communicate and was going for external medical treatments independently.

A review of the clinical record indicated that on a specified date the resident's health condition deteriorated. RPN #101 contacted the Physician on call and obtained a physician's order for a further test. The specified test was performed one week after it was ordered.

A review of the test result indicated it was faxed to the home on a specified date and time, one day after it was performed. The result was marked by the fax-machine with the date and time when it was received and stamped manually on the same day as received. The test result stated that the indication for the test was a specified health condition. The result further indicated that a specific diagnosis was suspected and that close follow up was recommended. The test result further indicated that it required immediate action. Interview with the Physician indicated the test result was not shared with them when the result was received at the home.

A review of resident #001's clinical record indicated the test was conducted on a specified date, one week after the resident completed a combination of treatments. On a specific date their health condition deteriorated again. They were on a specific on-going treatment. On a specified date, resident #001’s health condition deteriorated, and RN #102 transferred them to hospital. Several days after the hospitalization RN # 107 was informed that the resident had multiple conditions that they were treated for and that the condition was improving. According to interview with the Physician the resident improved with the initial therapy and deteriorated again. The resident was going for external treatments regularly, as per the schedule and had been monitored at the treatment unit.

Interview with the representative from the medical service company indicated that because of the concerning result of the test, this type of result was labeled as "stat" and was considered high risk or urgent, and further action was required. The Physician was expected to be notified immediately. The representative from the medical service company tried to call the home on a specified date, when the result was faxed, to discuss the results; they were not able to connect with any staff in the home as their call went unanswered.

Interview with the DOC indicated that the home was in COVID-19 outbreak during April 2020 and the staff worked under pressure. They investigated why resident #001's test result was not followed up immediately, and were not able to find out which staff received the result from the fax machine and stamped it as received. The registered staff who worked day and evening shifts did not remember receiving the results on the specified date. Registered staff RN #107 found the result in the physician's book several days after it was received and contacted the Physician, but the resident was already in hospital.

According to the interview with the Physician, during the COVID-19 outbreak Physicians were not coming to the home to assess residents in person, they had to be called or the results faxed to them.

During interviews with the DOC and ADOC they further acknowledged that the test result for resident #001 was received at the home on a specified date, and it was not reviewed and communicated with the home's Physician immediately, for further treatment of the resident. [s. 26. (3) 18.]

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 of care was based on an interdisciplinary assessment of special treatments and interventions, to be implemented voluntarily.

Issued on this 22nd day of July, 2020

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

Original report signed by the inspector.