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

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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
Nov 3, 2020	2020_631210_0014	000648-20, 000649-20, 003487-20, 003931-20, 004836-20, 009696-20, 009909-20, 015388-20, 015670-20	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

SLAVICA VUCKO (210), NITAL SHETH (500)

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): September 25, 28, 29, 30, October 2, 5, 6, 7 and 8, 2020.

During the course of the inspection the following Critical Incident System (CIS) reports were inspected:
-Intake #009909-20 related to falls prevention and safe and secure home;
-Intake #003487-20 related to falls prevention;
-Intake #009696-20 related to falls prevention;
-Intake #015388-20 related to abuse prevention;
-Intake #015670-20 CO related to personal care, and is included in inspection #2020_631210_0015;
-Intake #018263-20 related to abuse prevention. This intake was inspected together with a complaint, intake #018234-20, and the finding (sec. 3(1) 1. related to resident rights) is included in inspection report #2020_631210_0015.
-Intake #005117-20 related to falls prevention. This intake was inspected together with a complaint, intake #016937-20, and the findings (sec 6.7 related to the care plan, and 6 (9)1 related to personal care) are included in inspection report #2020_631210_0015.
-Intake #000649-20 and 22648-20, follow up on compliance from inspection #2019_751649_0022 related to falls and transfer.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Director of Environmental Services (DES), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist (PT), Food Service Supervisor (FSS), and Personal Support Workers (PSWs).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **5 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2019_751649_0022	210
O.Reg 79/10 s. 48. (1)	CO #002	2019_751649_0022	210

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the home was a safe and secure environment for resident #016.

A CIS was submitted to MLTC on a specified date regarding an incident that caused an injury to resident #016 for which the resident was taken to hospital.

Resident #016 was using a wheelchair for locomotion, and was able to self-propel with the wheelchair. On a specified date and time the resident was found by an identified staff at the bottom of stairs leading to the main floor. The resident was transferred to hospital for further assessment and was diagnosed with possible injury. Upon return from hospital, the resident's health status did not change and it was at their baseline.

The home conducted an investigation and identified that before the incident the door was used by an identified staff who did not check for wandering residents and if the door was closed after exiting.

The ED acknowledged that the door leading to the stairwell was not safely used on a specified date, by staff.

Sources: CIS report, resident #016's care plan, staff orientation check list, interviews with DOC, ADOC, FSS, BSO lead and DOES. [s. 3. (1) 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 the home was a safe and secure environment for resident #016, to be implemented voluntarily.

WN #2: 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 resident #020 was protected from physical abuse by resident #019 on July 26, 2020.

Resident #019 accused resident #020 of stealing their personal items, and pulled part of resident #020's body, which caused resident #020's body part to bleed.
Resident #019's care plan indicated that the resident does understand what they were doing.

Interviews with ADOC #102 and BSO lead #103 acknowledged that resident #020 was physically abused by resident #019.

Sources: Resident #19's care plan, CIS report, Prevention of Abuse and Neglect of a resident policy (#VII-G-10.00, revised April 2019), interviews with ADOC #102 and other staff. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: 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 CIS related to physical abuse was immediately reported to the Director.

A CIS submitted to MLTC indicated that an incident between resident #019 and resident #020 occurred on a specified date and was reported to the Director on the next day.

Interview with ADOC #102 acknowledged that the incident should have been reported immediately to the Director.

Sources: CIS report, interview with ADOC #102. [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 abuse of a resident by anyone that resulted in harm or a risk of harm to the resident is reported immediately to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident #017's resident-staff communication and response system, was easily seen and accessed by the resident.

A review of a picture sent by the ADOC to DOC by email, on a specified date, indicated resident #017's call bell was left on a location where the resident could not reach it.

Interviews with PSW #113 and ADOC #101 acknowledged that the call bell should always be within reach of the resident.

Sources: Picture, interviews with PSW #113 and other staff, Call bell Response Policy (#VII-H-10.00, April 2019) [s. 17. (1) (a)]

WN #5: 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 PSW #113 used safe transferring techniques when assisting resident #017 on a specified date.

The home investigated inappropriate transfer of resident #017 as per the resident's report to home's staff.

The most recent care plan of resident #017's, indicated that staff to use mechanical aid-hoyer lift with two people assistance for all transfers of the resident.

PSW # 113 acknowledged that when they transferred resident #017 there were not two people using the hoyer lift.

Sources: CIS report, Resident #017's care plan, interviews with PSW #113 and other staff. [s. 36.]

Issued on this 10th day of November, 2020

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

Original report signed by the inspector.