Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: February 24, 2023	
Inspection Number: 2023-1359-0003	
Inspection Type: Critical Incident System	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Weston Terrace Care Community, Toronto	
Lead Inspector Nicole Ranger (189)	**Inspector Digital Signature** Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2023.03.13 11:19:57 -04'00'
Additional Inspector(s) Inspector Yannis Wong (000707) was present during this inspection	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
January 25, 26, 27, 30, 31, February 2, 3, 2023.

The following intake(s) were inspected:
- Intake: #00010811 (CIS # 2874-000037-22) related to resident with unknown injury.
- Intake: #00015075 (CIS # 2874-000041-22) related to fall prevention and management.

The following intakes were completed:
- Intake: #00003288 – (CIS #2874-000023-22) related to fall prevention and management.
- Intake: #00003572 – (CIS #2874-000012-22) related to fall prevention and management.
- Intake: #00003959 – (CIS #2874-000022-22) related to fall prevention and management.
- Intake: #00006675 – (CIS #2874-000007-22) related to fall prevention and management

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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.

Rationale and Summary

i) On an identified date, Personal Support Worker (PSW) #106 assisted resident #001 to their washroom, provided care, and assisted the resident back to bed. Shortly after, PSW #106 heard the resident calling out, went into the resident's room and found resident #001 lying on the floor beside the bed. RPN #103 assessed the resident who was found with an injury. Resident #001 was transferred to the hospital on the same day and passed away later in hospital.

Resident #001 was high risk for falls and required fall interventions. PSW #106 reported that on the day of the incident, when they assisted the resident with care, an identified fall prevention intervention was not in place and they did not apply the fall prevention intervention to the resident. PSW #106 reported they went into the resident's room and found the resident on the floor by the bed, and called RPN #103 to assess. RPN#103 assessed the resident who was found with injury. RPN #103 confirmed that the fall intervention was not in place at the time of the incident.

ADOC #108 acknowledged that the fall intervention was not in place at the time of the fall.

Failure to ensure that staff applied the fall intervention placed resident #001 at risk of injury.

Sources: Resident #001's written plan of care, progress notes, homes investigation notes, CIS report #2874-000041-22, interviews with PSW #106, RPN #103, RPN #104 ,ADOC #108 and other staff.

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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.

Rationale and Summary

ii) On an identified date, Personal Support Worker (PSW) #109 was in the hallway and overheard resident #002 calling out. PSW #109 went to the room and found the resident sitting on the floor near the washroom with their mobility aid nearby. PSW #109 informed the nurse and RPN #110 assessed the resident who was found with no injury but in pain. On an identified date, the resident complained of pain and the physician ordered an x-ray of a body area. X-ray results showed no acute injury or finding. The resident continued to experience pain. On an identified date, the resident had a change in condition and was sent to hospital and diagnosed with an injury.

Resident #002 was high risk for falls and required fall prevention interventions. RPN #110 reported that on the day of the incident, when they assessed the resident they were wearing non skid socks inside of shoes that were not non skid. RPN #110 reported that at the time of the incident, the resident had other shoes in the room that were non skid. RPN #110 requested that the family remove the shoes from the room. RPN #103 confirmed that the resident was not wearing non skid shoes at the time of the incident and was later found to have an injury.

Failure of staff to ensure resident wore proper foot wear placed resident #002 at risk of injury.

S**ources:** Resident #002's written plan of care, progress notes, home's investigation notes, CIS report #2874-000037-22, interviews with PSW #109, RPN #110, ADOC #108, DOC #100 and other staff.

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WRITTEN NOTIFICATION: DOORS IN A HOME

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that doors leading to non- residential areas were kept closed and locked when not supervised by staff.

Rationale and Summary

On January 25, 2023, the W Linen room door on an identified resident home area (RHA) was open and unlocked. There were no residents in the vicinity at the time of the observations. Personal Support Worker (PSW) #117 reported that the door was like this for some time and then closed the door immediately.

On January 25, 2023, the E Soiled Utility room door on an identified RHA was open an unlocked. There were no residents in the vicinity at the time of observation. Maintenance staff #119 reported that the door should be closed and locked, and they will adjust the door closure.

A second observation was conducted on February 3, 2023, and the E Soiled utility room was found to be locked, however the W Linen room door on an identified RHA was open and unlocked. The inspector was able to push the door open, and it was not able to be closed and locked fully.

Director of Environmental Services (ESM) reported that the door closure for the W linen room door was not working and the door lock needs to be replaced.

The ESM acknowledged that the linen rooms were non-residential areas and must remain closed and locked.

Sources: Observations on January 25 and February 3, 2023, interviews with PSW #117, Maintenance staff #118 and #119, and Director of Environmental Services # 115

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

Rationale and Summary

On January 25, 2023, during meal observation, PSW #116 assisted resident #004 with their meal. After the meal was completed, PSW #116 was observed to use a cleansing wipe and wiped resident #004's face, then proceeded to use the same wipe to wipe the resident's hands. The cleansing wipe used to clean the resident's hands also did not contain alcohol.

Both the Infection Prevention and Control (IPAC) Lead #102 and PSW #116 acknowledged that a separate wipe should have been used for each area of the body part to be cleaned.

There was a risk of infection transmission to resident #004 when staff did not follow the home's IPAC practices.

Sources: Observation of dining services on January 25, 2023, interview with PSW # 116 and IPAC Lead # 102.

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COMPLIANCE ORDER CO # NURSING AND SUPPORT SERVICES

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 11 (3)

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 155 (1) (b):

Specifically, the licensee shall prepare, submit and implement a plan to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

The plan must include but is not limited to the following;
(a) A process to ensure that a registered nurse is on duty and present in the home at all times.
(b) Outline steps to take when a registered nurse is not available, including methods to ensure a registered nurse is present in the home at all times.
(c) Scheduling Coordinator and any individual who assists with scheduling receives training on items (a) and (b).
(d) The plan should include identified staff roles and responsibilities for the implementation and evaluation of the above process. A timeline is to be established for the implementation of each component of steps (a) through (c) by the compliance due date.

Please submit the written plan for achieving compliance for inspection #2023-1359-0003 to Nicole Ranger (189), LTC Homes Inspector, MLTC, by email to torontodistrict.mltc@ontario.ca by March 10, 2023.

Grounds
The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Record review and interviews with the Scheduling Coordinator, Director of Care and Executive Director on February 3, 2023, regarding 24 hour nursing care confirmed the following:

There was no registered nurse on duty at the home during the night shift on the following dates:
November 2022 – 11 shifts
December 2022 - 21 shifts
January 2023 – 17 shifts

The Director of Care (DOC) and Executive Director (ED) both acknowledged that at least one registered nurse is required to be on duty and present in the home at all times.

Failure to have a registered nurse on duty at the home on the above mentioned dates compromised nursing leadership available and accessible to nursing staff.

Sources: Review of staffing schedule for November, December 2022 and January 2023, interviews with RPN #104, Scheduling Coordinator #114, Director of Care #100 and Executive Director #101.

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This order must be complied with by March 31, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.