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
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Original Public Report

Report Issue Date: June 6, 2023	
Inspection Number: 2023-1359-0006	
Inspection Type: Complaint 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 Maya Kuzmin (741674)	**Inspector Digital Signature** Maya Kuzmin Digitally signed by Maya Kuzmin Date: 2023.06.07 09:17:19 -04'00'
Additional Inspector(s) Cindy Cao (000757)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 24-26 and 29-31, 2023.

The following intake(s) were completed in this complaint inspection:

- Intake: #00086805 was related to falls prevention and management.

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake: #00084669 was related to resident care and support services.
- Intake: #00085488 was related to a physical altercation between residents.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints

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 failed to ensure that assistance as specified in resident's plan of care was provided to a resident on an identified date.

Rationale and Summary

The resident required two-person care by a certain number of staff as specified in their plan of care.

On an identified date, a staff member provided care to the resident independently. When the staff left to get additional supplies, they returned and found the resident on the floor. The resident sustained an injury and required hospitalization.

The Director of Care confirmed that staff did not provide care as set out in resident's plan of care.

Failure to provide the resident with care as specified in their plan of care resulted in an injury to the resident.

Sources: Resident's clinical records, the Long-Term Care Home (LTCH)'s investigation notes; and interviews with staff.

[000757]

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that resident #002 was protected from physical abuse by resident #001.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a

resident that causes physical injury to another resident."

Rationale and Summary

On an identified date, a registered staff observed an altercation between residents. As a result of the incident, resident #002 sustained an injury.

A staff was assigned to monitor resident #001. The staff communicated to a registered staff that they would be leaving the floor. The registered staff agreed to monitor resident #001, however, they left them unattended to complete medication administration. When they returned, they saw resident #001 physically hurting resident #002.

DOC #101 acknowledged that resident #002 experienced physical abuse by resident #001.

Failure to provide monitoring for resident #001 resulted in resident #002 experiencing physical abuse by resident #001.

Sources: Critical Incident; resident #001's and resident #002's clinical records; interviews with staff.

[741674]

WRITTEN NOTIFICATION: General requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee failed to ensure that a resident’s responses to fall interventions were documented.

Rationale and Summary:

On an identified date, a resident fell and was transferred to hospital. They returned from hospital and were assessed by Physiotherapist (PT) who recommended fall interventions.

The home’s policy directed staff to update the plan of care with changes to the resident specific interventions as appropriate.

On an identified date, the resident’s care plan related to fall interventions was updated. The resident declined to use these interventions and later, the fall intervention was changed.

PT indicated that resident at times refused specific fall interventions, but this was not formally documented. Furthermore, Assistant to Director of Care (ADOC) #106 acknowledged they had updated the care plan for the resident with fall interventions as recommended by the PT as it was not completed by the registered staff.

Failure to document the resident's responses to fall interventions may have put resident at further risk of falls.

Sources: Falls Prevention and Management Policy (VII-G-30.10 revised April 2023); resident's clinical records; and interviews with staff.

[741674]

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee failed to ensure that a resident's behaviour strategies were implemented on an identified date.

Rationale and Summary:

A resident required additional monitoring to manage their responsive behaviours.

A staff was assigned to provide a resident with extensive monitoring. They left on their scheduled break and notified the registered staff who was not able to monitor resident #001. As a result, physical altercation occurred between resident #001 and resident #002.

Failure to implement responsive behaviour strategy for resident #001 resulted in altercation between resident #001 and resident #002.

Sources: Resident's care plan and progress notes; and interviews with staff.

[741674]