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: November 08, 2023	
Inspection Number: 2023-1359-0008	
Inspection Type: Critical Incident	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Weston Terrace Community, Toronto	
Lead Inspector Maya Kuzmin (741674)	**Inspector Digital Signature** Maya Kuzmin Digitally signed by Maya Kuzmin Date: 2023.11.27 08:47:44 -05'00'
Additional Inspector(s) Manish Patel (740841)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 27, 30, 31, 2023 and November 1, 2, 2023

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

- Intake: #00089199/CI#2874-000017-23 was related to alleged staff physical abuse to resident resulting in injury.
- Intake: #00090588/CI#2874-000020-23; Intake: #00090838/CI#2874-000021-23; Intake: #00096285/CI#2874-000033-23; Intake: #00097850/CI#2874-000039-23; Intake: #00097950/CI#2874-000038-23 were related to falls prevention and management.
- Intake: #00092334/CI#2874-000028-23 and Intake: #00098586/CI#2874-000040-23 were related to Infection Prevention and Control.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to Minimize Restraining of Residents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 33 (1) (b)

The licensee has failed to ensure that the restraining of a resident by a physical device was done in accordance with this Act and the regulations; and ensure that the restraint minimization policy was complied with for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that 'Restraint Implementation Protocols - VII-E-10.00' policy was complied with.

Specifically, the staff had restrained a resident by tilting the wheelchair without appropriate assessment, care planning, physician order, consent, education about the risk to the resident / substitute decision maker, and monitoring; as required by 'Restraint Implementation Protocols, VII-E-10.00' policy.

Rationale and Summary:

Inspector observed a resident sitting in a wheelchair which was tilted.

The records revealed there was no restraint assessment, care plan, physician order, consent, education about the risk to the resident / substitute decision maker, or monitoring.

A direct care staff, a registered staff and Physiotherapist (PT) confirmed the resident could get up independently from the wheelchair when seated in an upright position. However, the resident would not be able to get up if they were seated in a tilted wheelchair. The staff identified that the resident was seated tilted in the wheelchair and this position prevented them from getting out of the wheelchair, therefore a restraint to the resident.

Director of Care (DOC) confirmed that the staff did not follow the home's policy.

A direct care staff and a registered staff acknowledged that was greater risk of injuries to the resident with the use of a tilted wheelchair as a physical restraint.

Sources: observations of a resident; resident's records; Restraint Implementation Protocols policy - VII-E-10.00 (last revised: April 2019); and interviews with staff.

[740841]

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident received an assessment of their altered skin integrity by a member of the registered nursing staff, using a clinically appropriate assessment instrument.

Rationale and Summary:

On a specified date, resident #001 was identified with altered skin integrity.

The home's policy stated that when a resident exhibited altered skin integrity, a registered staff will complete an electronic skin and wound assessment using the Point Click Care (PCC) skin and wound application.

A registered staff stated that they did not complete a skin and wound assessment on the resident. DOC confirmed that staff are expected to complete an assessment of altered skin integrity.

Failure to complete a clinically appropriate assessment placed the resident at risk of compromised monitoring and treatment of their altered skin integrity.

Sources: Resident's documentation; Skin and Wound Care Management Protocol Policy, VII-G-10.90 (last revised August 2023); and interviews with staff.

[741674]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee has failed to ensure that symptoms indicating the presence of infection were monitored for a resident, in accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes.

The Infection Prevention and Control Lead (IPAC lead) failed to ensure that the home employed syndromic surveillance regularly to monitor for symptoms, including but not limited to, fever, new coughs, nausea, vomiting, and diarrhea, and taking appropriate action in accordance with the "IPAC Standard for Long-Term Care Homes April 2022" (IPAC Standard).

Specifically the IPAC lead did not ensure that symptoms indicating presence of infection were monitored for a resident on a specified date as is required by the Additional Requirement under 3.1 (i) under the IPAC Standard.

Rationale and Summary:

A resident was documented to return from hospital with an infection and was placed on contact precautions.

Resident's records reviewed on specific dates failed to mention that the resident had an infection, nor that it was being monitored. IPAC lead confirmed that documentation did not exist in relation to monitoring signs and symptoms of infection for the resident.

Failure to monitor and document a resident's infection placed them at risk of receiving compromised treatment.

Sources: resident's documentation; and interviews with IPAC #106.

[741674]