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

Public Report

Report Issue Date: February 3, 2025

Inspection Number: 2025-1359-0001

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 22 -24, 27 -31, 2025 and February 3, 2025

The following intake(s) were inspected:

- Intake: #00130935 - Critical Incident System (CIS) 2874-000072-24 - related to Medication management
- Intake: #00132590 - CIS 2874-000075-24 - related to Fall Prevention and Management
- Intake: #00132694 - CIS 2874-000076-24 - related to Resident Care and Support Services

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

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

During the inspection, the utility doors in two resident home area (RHA) were unlocked. The inspector opened the door and observed chemicals along with other items inside. There were no residents in the vicinity at the time of the observations.

The Director of Environmental Services (DES) and Director of Care (DOC) both acknowledged that the utility rooms were non-residential areas and the doors must remain closed and locked.

Sources: Observation on January 22, 2025, interview with the DES and DOC.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOUR

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure actions were taken including assessments and interventions and documented when a resident demonstrated a responsive behaviour.

A resident demonstrated a new responsive behaviour towards staff and a visitor. At the time of the occurrence, a referral for an assessment was not completed for the resident, and no responsive behaviour interventions were implemented.

Sources: Review of resident's care plan and progress notes, the home's Responsive Behaviour Management Policy (Policy #VII-F-10.10) last revised on October 2024, and interview with a Registered Nurse, ADOC, and BSO Lead.

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 (15) 3.
Infection prevention and control program

s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
3. In a home with a licensed bed capacity of 200 beds or more, at least 35 hours per week. O. Reg. 246/22, s. 102 (15).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) lead designated under this section works regularly in that position on site at the home for at least 35 hours (hrs) per week.

The DOC indicated they were the previous Infection Prevention and Control (IPAC) Lead, and in the interim they were currently supporting to oversee the IPAC program in conjunction with Assistant Director of Care (ADOC). Both the DOC and ADOC reported they worked between 20 hours per week to perform IPAC duties and confirmed that they have additional roles in the home. There was no designated IPAC lead who works 35 hours per week in the IPAC Lead role in the home.

Sources: Interview with the DOC and ADOC.

WRITTEN NOTIFICATION: QUARTERLY EVALUATION

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets

at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee failed to ensure that an interdisciplinary team meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The Professional Advisory Committee (PAC) meets for quarterly evaluation of the medication management system including the quarterly review of all medication incidents. The home did not meet at least quarterly to evaluate the effectiveness of the medication management system to recommend any changes necessary to improve the system for two quarters.

Sources: review of PAC meeting minutes, review of medication incidents, and interviews with the ADOC and DOC.

WRITTEN NOTIFICATION: RESIDENT RECORDS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (a)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home.

The licensee has failed to ensure responsive behaviour monitoring records were maintained for a resident.

According to the resident's progress notes, a responsive behaviour monitoring tool was initiated on two specified dates for the resident. The monitoring document could not be produced when it was requested from the home.

Sources: Resident's clinical records, interviews with the BSO Lead.

COMPLIANCE ORDER CO #001 MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (a)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 147 (2) (a) [FLTCA, 2021, s. 155 (1) (b)]:
The licensee shall prepare, submit and implement a plan to ensure that all medication incidents, occurrences of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed.

The plan shall include but is not limited to:

- Process to ensure all outstanding medication incidents are reviewed and analyzed by the home and pharmacy.
- Create and develop a plan to ensure that when medication incidents in the home occur, they are reviewed and analyzed by the home and pharmacy.
- The plan should include identified staff roles and responsibilities, and a timeline is to be established for the implementation of each component mentioned above within the compliance due date.

Please submit the written plan for achieving compliance for inspection #2025-1359-0001 to LTC Homes Inspector, MLTC, by email to torontodistrict.mltc@ontario.ca by February 14, 2025.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure that all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed.

Medication incidents were reviewed for a six month period. Medication incidents, including incident of administration of glucagon, and incidents of severe hypoglycemia were not reviewed and analyzed by the home or pharmacy.

The ADOC verified these medication incidents were not reviewed and analyzed as required by the home.

Sources: review of residents medication incidents and Medication Administration Record (MAR), interview with the ADOC.

This order must be complied with by : March 28, 2025

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

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.