Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 17, 2017	2017_370649_0002	020445-16, 031986-16, 032956-16, 033729-16, 033743-16, 034581-16, 034924-16, 035139-16	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO 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

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 9, 11, 12, 27, 30, 31, and February 1, and 3, 2017.

The following Critical Incident System (CIS) intake was conducted concurrently with this complaint inspection: 033729-16.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Associate Director of Care (ADOC), Resident Assessment Instrument (RAI), Coordinator, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Physiotherapist (PT), Resident and family member.

During the course of the inspection, the inspectors toured the home, observed resident care, observed staff to resident interactions, meal delivery services, reviewed health records, reviewed the home's staff training records, staff schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. 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.

(1) In November 2016, a complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) action line that staff were not following an identified resident's plan of care.

On an identified date in January 2017, the inspector observed the identified resident sitting in his/her wheelchair in the dining room without a device in place as directed in the plan of care.

Record review of the identified resident's most current plan of care under the section titled moderate risk for falls directed staff to apply the device while the resident is sitting in the wheelchair.

Interview with personal support worker (PSW) #103 revealed that he/she had just gotten the resident up out of bed and had forgotten to apply the device, he/she immediately went to the resident's room and retrieved it, applied it to the resident's clothing.

The Assistant Director of Care (ADOC) #127 was present in the dining room and the inspector brought this failure to provide care as specified in the plan to his/her attention. The ADOC told inspector that the device should have been applied to the resident while he/she was sitting in the wheelchair.

(2) In November 2016, a CI was submitted to the MOHLTC reporting that the identified resident's device was not applied as per the manufacturer's instructions.

Record review of the identified resident's November 2016 plan of care, under a specified section directed staff to apply the device while the resident is up in the wheelchair for safety.

A review of the home's investigation notes revealed that PSW #121 had noticed the identified resident's device had not been applied while the resident was in the dining room and he/she had advised PSW #124 who immediately applied the device.

Interview with PSW #124 revealed that he/she recalled that the identified resident's

device had not been applied on a morning in November 2016, while in the dining room and recalled applying the device when it had been brought to his/her attention by another PSW.

Interview with the Director of Care (DOC) revealed that all staff had been trained on the application of the device and they have to ensure that the device is properly applied. [s. 6. (7)]

2. In July 2016, a complaint was submitted to the MOHLTC action line stating that the feeding protocol was not being followed as per the plan of care for an identified resident.

On an identified date in January 2017, the inspector observed that the resident had been offered specified fluids during the dinner meal.

Record review of the identified resident's most recent written plan of care under nutritional care directed staff to provide the resident with two servings of an identified beverage and two servings of identified milk at lunch and dinner.

The inspector inquired with PSW #104 if the correct fluids had been offered to the resident the PSW then removed the specified fluids from the resident.

The inspector observed PSW #104 bring a second serving of identified fluids to the resident.

The inspector inquired again with PSW #104 if the identified resident had been offered the correct fluids according to the plan of care and the PSW again removed the identified fluids.

The inspector observed that PSW #104 brought the resident a third serving of identified fluids.

The ADOC #127 was present in the dining room and the inspector brought this failure to follow the plan of care to his/her attention. He/she told the inspector that staff should have followed the plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

In December 2016, a complaint was submitted to the MOHLTC action line related to an identified resident's restraining device was extremely tight.

Observations in January 2017, revealed that an identified resident did not have the identified device in place.

Record review revealed that the identified device had been discontinued in December 2016.

Record review of the the identified device documentation in Point of Care (POC) revealed incomplete documentation by the registered staff on identified dates in November 2016.

Interview with registered nurse (RN) #125, registered practical nurses (RPN) #118, #102, and #132 told the inspector they had evaluated the resident's device but did not document in POC on identified dates in November 2016.

Interview with the DOC revealed that it is the home's expectation that there is an evaluation by the registered staff at the the end of each shift of the identified device on the above mentioned dates. [s. 6. (9)]

4. In December 2016, a complaint was submitted to MOHLTC that staff were not following the bowel routine for an identified resident.

Record review of the identified resident’s bowel and bladder records revealed on identified dates in May and November 2016, the administration of a prescribed medication had not been documented in the medication administration record (MAR). Resident has a history of problems related to an identified issue and was transferred to the hospital in February and August 2016, and diagnosed and treated for the identified medical condition.

In May 2016, the MAR directed staff on a specified day with no pattern of elimination to administer prescribed medications. Record review of the identified resident’s last pattern of elimination was on an identified date in May 2016. Review of the MAR revealed that none of the medications were documented as given on the specified date in May 2016, after the resident had not had a pattern of elimination for specified days.

In November 2016, the MAR directed staff on a specified day with no elimination to

administer prescribed medications. Record review of the identified resident's last pattern of elimination was on an identified date in November 2016. Review of the MAR revealed that no medication was documented as given on the specified date in November 2016, after the resident did not had a pattern of elimination in a specified time.

Interviews with RPNs #101 and #107 revealed that there was no documentation on the MAR that the resident had been given the medication on identified days in May and November 2016, and that the resident should have received the medication sooner.

Interview with the DOC and ADOC #108 confirmed that there had not been any documentation for the administration of medication to the identified resident on the above mentioned dates. [s. 6. (9) 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 the care set out in the plan of care is provided to the resident as specified in the plan and that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: 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 the staff use safe transferring and positioning devices or techniques when assisting residents.

In November and December 2016, complaints were submitted to the MOHLTC action line stating that improper transfer techniques were being performed for an identified resident related to the use of a specified size apparatus.

Record review of the identified resident's lift and transfer assessments revealed that no assessment had been completed when the resident had started to use the apparatus for transfers in June 2016. Further review indicated that the resident had been using an identified size apparatus from June until August 2016, when the apparatus was reassessed and this size changed.

Interview with the physiotherapist (PT) #120 revealed that if a resident is placed in too large an apparatus this could be dangerous for the resident and he/she could fall through.

Interview with the DOC revealed that the identified resident had not been assessed in June 2016, when the specified size apparatus had been used for the resident's transfers. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: staff apply the physical device in accordance with any manufacturer's instructions.

In November 2016, a CI was submitted to MOHLTC reporting that an identified resident's device was observed by the substitute decision maker (SDM) wrapped around an identified part of the wheelchair.

Review of the home's investigation notes revealed that PSW #124 had provided a statement that the identified resident's device was wrapped around an identified part of the wheelchair on an identified date in November 2016.

PSW #124 told the inspector that he/she had not applied the resident's device properly on an identified date in November 2016. PSW #124 stated that he/she knows how to properly apply the device.

Interview with ADOC #108 revealed after investigation he/she had reported to the resident's SDM that the resident's device had not been correctly applied on an identified date in November 2016.

Interview with the DOC revealed that all staff had been trained on the application of the device and they have to ensure that the device is properly applied according to the manufacturer's instructions. [s. 110. (1)]

2. The licensee has failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: that the resident's condition is reassessed and the effectiveness of the restraining evaluated by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

In December 2016, complaints were submitted to the MOHLTC action line related to an identified resident's device was extremely tight.

Record review of the identified resident's device documentation in POC completed by the registered staff every shift indicated incomplete documentation on identified dates in November 2016.

Interview with RPN #101 revealed that he/she had not evaluated the resident's device on the above dates and was unaware that the resident was using the identified device.

Interview with DOC revealed that registered staff have a responsibility to ensure that resident's device had been evaluated every eight hours and documented in POC. [s. 110. (2) 6.]

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 following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: staff apply the physical device in accordance with any manufacturer's instructions and the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: That the resident's condition is reassessed and the effectiveness of the restraining evaluated by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

In November and December 2016, complaints were submitted to the MOHLTC action line reporting an identified resident had impaired skin integrity on an identified body area.

Record review of the identified resident's progress notes indicated that the resident was transferred to the hospital on an identified date in May 2016, and had returned on same day. Further review indicated that no head to toe skin assessment had been completed when resident returned from the hospital on the identified date in May 2016. A review of the current written plan of care indicated that the resident was at risk for impaired skin integrity on identified body areas.

Interview with resident assessment instrument (RAI) Coordinator revealed that no head to toe skin assessment had been completed in May 2016, when resident had returned from the hospital.

Interview with the DOC revealed that it is the home's expectation that the registered staff who admits the resident completes a head to toe skin assessment upon the resident's returned from the hospital. [s. 50. (2) (a) (ii)]

Issued on this 22nd day of February, 2017

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

Original report signed by the inspector.