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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 21, 2018	2018_634513_0014	005142-17, 017842-17, 023003-17, 023488-17, 026772-17, 005140-18, 020867-18	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

JUDITH HART (513), PRAVEENA SITTAMPALAM (699)

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): October 18, 19, 22, 23, 24, 25, 26, 29, 30, 31, November 1, 2, 5, 6, 7, 8 and 9, 2018.

During this inspection the following intakes were inspected: intake log #017842-17 and #026772-17, related to abuse; #023488-17, and #021339-18 CIS #2874-000038-18, related to falls; #020867-18, related to medication concerns; #023003-17, with corresponding CIS #2874-000027-17, related to abuse and #005140-18, related to environmental concerns.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Resident Care (DRC), Associate Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Responsive Behaviour Lead, Personal Support Workers (PSW), Director of Environmental Services, Registered Dietitian (RD), Dietary Manager, Receptionist, residents and family members.

During the course of the inspection, the inspectors conducted observations in resident home areas, observed care delivery processes including the mobility and transfer of residents, food and fluid intake, reviewed the home's policies and procedures and residents' health records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Légende 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The licensee had failed to ensure that there was a written plan of care that set out the planned care for the resident.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) regarding a specified alteration in bed mobility of resident #012, on an identified date in 2018.

A review of resident #012's care plan on a specified date in 2018, indicated the resident required extensive assistance with activities of daily living.

The progress notes on a specified date in 2018, identified resident #012's power of attorney (POA) for care requested that staff check the resident's identified extremity frequently when in bed. This direction was endorsed to the incoming staff to check resident #012's extremity frequently.

A review of the written care plan, subsequent to the above mentioned specified date in 2018, did not identify the request of the POA to check resident #012's extremity frequently.

An interview with RPN #114 identified that the POA requested staff to check the resident's extremity frequently when in bed. The frequent checking of the resident's extremity was not documented in resident #012's care plan.

An interview with the DOC confirmed the request of the POA regarding the frequent monitoring of resident #012's extremity was not documented in the care plan, therefore the resident's written plan of care did not set out the planned care for the resident. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM have been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was received by the MOHLTC that resident #021's SDM had not been notified of changes to the resident's treatment plan.

A review of resident #021's progress notes on a specified date in 2017, indicated the physician had discontinued specified treatments and prescribed other specified medications upon resident #021's admission to the home. A further review of the progress notes identified that resident #021's SDM was not notified of the medications changes.

An interview with RN #127 indicated that it was the nurse's responsibility to review the medications upon a resident's admission to the long-term care home and if the physician made changes to the resident's medication regimen, the family would be notified. RN #127 could not recall if they called resident #021's SDM regarding the medication changes prescribed by the physician.

In an interview with former ADOC #129 indicated that if there were changes to resident medications the SDM should be informed. ADOC #129 acknowledged that resident #021's SDM was not informed of the medication changes on admission to the home, therefore they did not provide the opportunity for the SDM to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

3. 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.

A complaint was received by the MOHLTC that indicated resident #011 sustained an

alteration in mobility.

A review of the progress notes identified on a specified date in 2017, resident #011 had an alteration in mobility without injury.

A review of the care plan on a specified date in 2017, indicated the resident was at a moderate risk for an alteration in mobility. The care plan indicated a specified intervention to be initiated.

Observations on four dates identified the specified intervention was not initiated.

An interview with RPN #114 identified the care plan for resident #011 indicated the specified intervention should be initiated and following an observation confirmed the intervention had not been initiated as per the plan of care.

An interview with the DOC acknowledged the plan of care for resident #011was not implemented as specified in the plan. [s. 6. (7)]

4. A complaint was received by the MOHLTC related to the administration of resident #021's nutritional treatment.

A review of the physician's prescribed treatments indicated to administer specified nutritional treatment volume at specific start and stop time intervals.

A review of resident #021's progress notes indicated that on a specified date in 2017, Registered Dietitian (RD) #126 noted at approximately 0945 h that resident #021 received a specified volume of nutritional treatment. The RD informed Registered Nurse (RN) #131 that the volume infused was high for the identified time. At 1430 h RD #126 called RN #131 to check the infused treatment volume. RN #131 informed RD #126 that the treatment volume was almost infused, with a specified volume reported. RD #126 then called the former Associate Director of Care (ADOC) #129, who requested the treatment be stopped at 1530 h.

A review of the home's investigation notes identified that resident #021's nutritional treatment was not turned off by RPN #117 the previous night as per the physician's order. A further review of the investigation notes indicated that on a specified date resident #021 received an additional specified volume of treatment.

An interview with RPN #117, indicated they thought they had turned off the treatment on a specified date at a specified time. RPN #117 indicated they were not aware that resident #021 continued to receive the treatment from midnight to a specified time for a period of six hours up to the next day, until they were notified by management. RN #131, who worked on the specified date, day shift, was unavailable for interview.

A review of the progress notes by RN #131 indicated the treatment was stopped on a specified date and time, after they and RD #121 identified resident #021 received their goal treatment volume. There were no progress notes by RN #131 for the specified date to indicate that RD #126 informed them of the potential of additional treatment, or that the resident was assessed for additional treatment in the morning on the identified date.

An interview with the DOC confirmed resident #021 received additional nutritional treatment on the specified date, more than what was prescribed, and therefore the care plan was not followed for resident #021. [s. 6. (7)]

5. A complaint was received by the MOHLTC related to improper positioning for resident #021.

A review of resident #021's care plan identified that resident #021 was receiving a specified treatment related to a medical diagnosis and during the treatment the resident was to be positioned as specified in the care plan.

A review of resident #021's progress notes indicated on a specified date the family member of resident #021 rang the call bell regarding the resident's treatment. The family member asked RPN #132 about the resident's positioning during the treatment. RPN #132 indicated the resident's position, notified the nurse manager, who came to observe the resident's position. The RPN and nurse manager's observations were not consistent with each other nor as specified in the care plan.

An interview with ADOC #110 indicated that resident #021's was not positioned as specified in the care plan and therefore the care plan was not followed. [s. 6. (7)]

6. A complaint was received by the MOHLTC that stated resident#022 had an identified injury from an unknown source. The resident was transferred to hospital and returned to the home with a specified medical diagnosis.

The Minimum Data Set (MDS) assessment indicated resident #022 required a specified

level of assistance for alterations in mobility.

A review of the home's investigation notes on a specified date indicated resident #022 was found with specified symptoms to an identified location. A further review of the investigation notes indicated that PSW #132 repositioned resident #022 for breakfast without assistance and did not note the specified symptoms until it was observed by the SDM.

An interview with PSW #132 indicated resident #022 required the above mentioned specified level of assistance for care and on the specified date. They independently assisted resident #022 to sit up at the bedside, assisted them with an item of clothing and assisted them with breakfast. PSW #132 indicated they did not notice the specified symptoms while assisting the resident with breakfast and returned to the room when the SDM notified staff of the resident's specified symptoms. PSW #132 indicated they did not follow resident #022's care plan related to providing care with a specified level of assistance.

An interview with ADOC #110 confirmed that resident #022's care plan indicated the resident required a specified level of assistance which they did not receive. [s. 6. (7)]

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 there is a written plan of care that sets out the planned care for the resident and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The Licensee had failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A complaint was received by the MOHLTC that stated resident #011 sustained an alteration in mobility.

In accordance with O. Reg 79/10 r. 49 (1), every licensee of a long-term care home shall ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimens, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

A review of the home's policy titled, Falls Prevention, reviewed January 2015, stated that when a fall occurs, staff should initiate a head injury routine (HIR) if a head injury is suspected or if the resident fall is unwitnessed and he/she is on anticoagulant therapy. The HIR identified scheduled checks every 15 minutes for the first hour, every 30 minutes for two hours, every hour for three hours, every 2 hours times four and then every four hours times three. The policy stated to monitor HIR as per the schedule on the form post fall for signs of neurological changes that included, but were not limited to: vital signs, pupil size, pupil size and response, motor response for upper and lower limbs and consciousness level.

A review of the resident's care plan on a specified date indicated resident #011 was at a moderate risk for an alteration in mobility.

A review of the progress notes on a specified date indicated resident #011 was found in a

specific position and location with an alteration in mobility. The resident was assessed and no injuries were found.

A review of the HIR for resident #011 indicated on specified dates and times the HIR was not documented.

An interview with RPN #114 indicated all HIR assessments should be completed as per the HIR protocol and confirmed the HIR assessments for resident #011 were not fully completed on the specified dates and times.

An interview with the DOC indicated the registered staff were expected to complete all HIR assessments for residents who have an unwittnessed alteration in mobility and in this instance staff did not follow the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. A complaint was received by the MOHLTC related to a specified nutritional treatment for resident #021.

A review of the home's policy titled Medication Reconciliation stated the medication reconciliation process was to compare the treatment list against the physician's admission, transfer, and/or discharge orders; identifying and bringing any discrepancies to the attention of the prescriber and other members of the health care team.

A review of the home's investigation notes on a specified date identified that on admission to the home, an incorrect treatment order was transcribed by RD #126, based on the information from the Community Care Access Center (CCAC) admission package, which was over a year old. The investigation notes indicated that the information sent from the local hospital, which contained the correct treatment order, was not reviewed by RD #126 nor the two RNs assigned to resident #021. The correct treatment was identified.

An interview with RD #126 indicated the documentation from the hospital was not complete, that they relied on the RN and ADOC to review the order and to verify the accuracy of the treatment for resident #021. RD #126 indicated they asked RN #127 to review resident #021's hospital documents and RN #127 told RD #126 that the medication list from the CCAC package was all they had received from the hospital. RD #126 stated it was the responsibility of the nurse to verify the treatment order.

An interview with RN #127 indicated they admitted resident #021 to the home on a

specified date and it was their responsibility to verify the treatment orders to make sure they were correct. They stated that RD #126 transcribed the order, however it was their responsibility to verify it and they did not verify that the order was correct.

An interview with ADOC #110 indicated it was the home's policy that the nurse should review, compare and verify the orders and call the physician when there is a discrepancy. In this instance, for resident #021, the discrepancy was not identified and the physician was not notified, therefore the reconciliation policy of the home was not followed. [s. 8. (1) (a),s. 8. (1) (b)]

3. A complaint was received by the MOHLTC regarding a prescribed medication for resident #012.

During the inspection, on November 1, 2018, the complainant raised a concern regarding a specified medication received by resident #012 on admission to the home in 2016, which was alleged to not be the correct dosage.

A review of the home's Medication Reconciliation policy, indicated the medication reconciliation process included creating the most complete and accurate list of medications currently being taken by the resident, using the list when writing medication orders, comparing the list against the physician's admission, transfer, and/or discharge orders, and identifying and bringing any discrepancies to the attention of the prescriber and other members of the health care team.

A review of the medication list from the pharmacy on a specified date in 2016, indicated the medication was to be administered at a specific frequency. A review of the resident's medications on admission to the home identified on the New Admission Order Form a prescription for a specified medication to be administered at another specified frequency.

A review of the resident's MAR indicated on admission that the resident received the medication at the frequency indicated on the New Admission Order Form.

An interview with RPN #101, who signed off the admission medications on the New Admission Order Form, could not recall how the medications were reconciled as time had passed, but agreed the physician prescription for the specified medication did not reflect the pharmacy frequency of administration.

An interview with the DOC acknowledged the process for the reconciliation of

medications, as per the home's medication reconciliation policy mentioned above. The medications were not reconciled for the specified medication for resident #012 as per the home's policy. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident's right to be properly groomed and cared for in a manner consistent with his or her needs is fully respected and promoted.

A complaint was received by the MOHLTC regarding related to uncleanliness of resident #011.

A photograph identified as IMG_20180908_07 was provided to Inspector #513 showing a brown substance on an identified area of resident #011's body.

A review of the progress notes indicated RPN #117 was approached by the SDM who showed them the resident's unclean body part. The progress notes also indicated the resident had soiled material on the skin of another identified location.

An interview with PSW #125 identified at times the resident would soil the first above mentioned body part themselves. When the staff would try to cleanse the area, the resident would at times pull away and staff were not able to clean them properly.

An interview with RPN #114 indicated at times resident #011 would not permit total cleaning of their identified body part and staff would then reapproach the resident. On one identified occasion in 2017, RPN #114 indicated they were called to the resident's room by the SDM to observe soiled linen. RPN #114 apologized to the resident and SDM and changed the linen.

An interview with the DOC indicated that staff were expected to clean resident #011's body part of soiled material and change soiled linen. In this instance resident #011 did not receive the care and linen change expected and therefore resident #011 was not properly groomed and cared for in a manner consistent with their needs. [s. 3. (1) 4.]

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 11th day of January, 2019

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

Original report signed by the inspector.