Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
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Original Public Report

Report Issue Date: March 31, 2023	
Inspection Number: 2023-1359-0004	
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 Parimah Oormazdi (741672)	**Inspector Digital Signature**
Additional Inspector(s) Arther Chandramohan (000720) was present during this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6-9, 2023

The following intake(s) were inspected:

- Intake: #00020233 was related to prevention of abuse and neglect.
- Intake: #00021110 was related to unknown cause of injury.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect a resident from neglect when a fall incident was not reported to the registered nursing staff soon after the fall to assess the resident.

Section 7 of Ontario Regulation 246/22 defines "Neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and summary
The home submitted a Critical Incident (CI) report, when a resident was found to have an injury. A few days later, through the home’s investigation process, it was identified that the resident had a fall, and the Personal Support Workers (PSWs) who were present did not report the fall to the registered nursing staff.

The Associate Director of Care (ADOC) and Director of Care (DOC) confirmed that the PSWs who were present at fall incident should have reported to the registered nursing staff soon after the incident occurred. They indicated that the resident could have sustained injury as a result of the fall and should have been assessed immediately.

Due to failure to report the fall incident to the registered nursing staff, the completion of required assessments and provision of treatment were delayed, placing the resident at risk of additional harm.

Sources: CI report, the home’s investigation notes, resident’s clinical record, interview with ADOC and DOC.
[741672]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and summary
A resident had a fall while being assisted by staff with transferring. The PSWs who transferred the resident, did not check the equipment for safety. As a result of the fall, the resident sustained an injury.

The home's policy titled Safe Resident Handling, VII-G-20.30, last revised on April 2019, stated " The PSWs will check the transferring equipment is functioning and positioned appropriately before moving resident."

The ADOC and DOC indicated that the functioning of transferring equipment should have been checked for safety prior to transferring the resident.

As a result of staff not using safe transferring techniques, the resident had a fall and injury.

Sources: Resident’s clinical records, interviews with ADOC and DOC. Policy titled Safe Resident Handling, VII-G-20.30, last revised on April 2019.
[741672]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

In accordance with O. Reg. 246/22, s. 54 (1) in reference to s. 11(1) (b), the licensee is required to ensure that a written policies and procedures are in place for the falls prevention and management program and are complied with.

Specifically, the PSWs who were present when a resident fell, did not comply with the Long-Term Care Home (LTCH)'s policy and procedure "Falls Prevention and Management - VII-G-30.10", last revised December 2021. The home's policy requires that when a fall occurs the team members will ensure the resident is not moved before the completion of a preliminary assessment.

Rationale and summary
A resident had a fall and the PSWs transferred the resident back to bed and did not report the fall to registered staff. Therefore, the PSWs did not comply with the policy and procedure for the resident during this time.

The ADOC confirmed that as per the home's fall prevention and management policy, the resident should not have been moved after the fall incident.

By not following the home's Falls Prevention and Management policy and procedure, the resident was put at higher risk of fall related injuries.

Sources: CI report, the home's investigation notes, resident's clinical record, Falls Prevention and Management Policy- VII-G-30.10, last revised December 2021, interview with ADOC.
[741672]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee failed to ensure that the registered nursing staff completed a diagnostic test for a resident in a timely manner as per the home's move-in check list and protocol.

Rationale and summary
A resident was admitted to the LTC home and their diagnostic swab test that should have been completed within first day of admission was missed. The registered nursing staff completed the swab test a few days later during night shift which resulted in the resident sustaining injury.

The home's move-in checklist indicates that the registered nursing staff should obtain swabs for the diagnostic test within 24 hours of admission. The Infection Prevention and Control (IPAC) lead also confirmed that the test should be always completed upon admission.

The ADOC indicated that the resident was admitted to the home the day prior to a long weekend which might cause the delay in testing to avoid storing the sample in fridge for a lengthy time. However, it was expected to be completed soon after the long weekend. They stated that the registered nursing staff did not complete the diagnostic test until eight days after the resident's admission.

Due to not completing diagnostic testing swab test for the resident in a timely manner, the registered nursing staff did not participate in the implementation of communicable disease screening and immunization program.

Sources: Resident's clinical health records, home's move-in checklist and protocol, interview with IPAC lead and ADOC.
[741672]