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

Original Public Report

Report Issue Date: March 11, 2024	
Inspection Number: 2024-1359-0002	
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 Jack Shi (760)	Inspector Digital Signature Jia J Shi Digitally signed by Jia J Shi Date: 2024.03.11 14:37:28 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6, 7, 8, 2024

The following Critical Incident intakes were inspected:

- Intake: #00103607- 2874-000049-23 – Related to an outbreak
- Intake: #00104075 - 2874-000051-23 – Related to an outbreak
- Intake: #00106487 - 2874-000007-24 – Related to an outbreak
- Intake: #00105270 - 2874-000059-23 – Related to a fall resulting in a significant change in status

The following Critical Incident intakes were completed in this inspection:

- Intake: #00105008 - 2874-000057-23 - Related to a fall resulting in a significant change in status
- Intake: #00105697 - 2874-000004-24 - Related to a fall resulting in a significant change in status

- Intake: #00106502 - 2874-000008-24 - Related to a fall resulting in a significant change in status

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that Registered Nurse (RN) #119 used safe transferring techniques after resident #001 sustained a fall.

Rationale and Summary:
A Critical Incident Systems (CIS) report was submitted to the Director indicating that resident #001 had sustained a fall that had resulted in a significant change in their status.

The home has a zero lift protocol which states that residents should be transferred using the application of mechanical lift devices and transfer aids. Furthermore, the home's policy on falls prevention and management indicates that residents who are suspected or demonstrate evidence of having an injury should not be moved.

According to the progress notes, the resident had a fall a day prior to the CIS incident. RN #117 had contacted the paramedics to attend to the resident due to the injury the resident sustained from their fall. The paramedics did not arrive during their shift and RN #117 endorsed to RN #119 to follow up. RN #119 stated that they wanted to transfer the resident off the floor before the paramedics came. The RN stated they called for two Personal Support Workers (PSWs) to assist in transferring the resident off the floor. The RN acknowledged that the transfer provided to the resident did not align with the home's policies and procedures.

Director of Care (DOC) #100 stated that RN #119 should have used the safest method of transferring a resident after a fall and that this did not occur. The DOC confirmed that the RN did not use a safe transferring technique on resident #001.

Failure to ensure that safe transferring techniques were being utilized for the resident may have resulted in further injury.

Sources: Investigation notes; CIS #2874-000059-23; Policy titled, "Falls Prevention & Management, VII-G-30.10" and "Zero Lift & Protocol, IV-M-10.10"; Interviews with RN #117, 119, DOC #100 and other staff; Resident #001's progress notes. [760]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the

resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,

(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee failed to ensure that the Director was notified within three business days after resident #001 sustained a fall, which led to a significant change in their condition.

Rationale and Summary:
A CIS was submitted related to a fall that resident #001 sustained at an earlier date, that resulted in a significant change. A little over a week prior to the CIS being submitted, the home had received information that the resident experienced a significant change in their health status. The DOC was aware that the legislation requires that in incidents where the licensee is unable to determine if an injury resulted in a significant change in the resident's health condition, that a report would still be required to be submitted to the Director within three business days of the incident. The DOC confirmed that this incident was reported late to the Director.

Sources: CIS # 2874-000059-23; Interview with DOC #100. [760]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246 / 22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The license shall:
1. Provide re-education to all nursing students currently in the home related to the four moments of hand hygiene, including when engaged in a medication pass. If there are no nursing students present in the home during the period of the service of this order by the compliance due date, then ensure that education materials are created for all future nursing students to indicate when hand hygiene should be performed during a medication pass.
2. Provide re-education to all direct care nursing staff including but not limited to PSWs and registered nursing staff (along with any of those who are from an agency) that work on the days and evening shifts on the requirement of providing residents with hand hygiene prior to their snacks.
3. Audit two selected periods of a snack pass on two random resident units per day for a period of two weeks to ensure hand hygiene is being provided to residents prior to receiving their snacks.
4. Maintain a record of the aforementioned training, including the dates, staff names and designation, signed attendance, training topics, and name and title of the person(s) who provided the training.
5. Maintain a record of the aforementioned audits, including the dates and times of the audits, the name(s) of the auditor, the names and designation of staff audited, results of audits and actions taken.

Grounds

i). The licensee has failed to ensure that PSW #111, 112, 113 and 114 provided hand hygiene to multiple residents on various units prior to providing their snacks to them.

In accordance to the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard), under section 10.4, section F, residents shall receive support from staff to perform hand hygiene prior to receiving meals and snacks.

Rationale and Summary:
The inspector observed PSW #111 providing snacks to residents on a unit. Multiple residents had their snacks brought to them in their rooms, but hand hygiene was not being provided to the residents when the snacks were delivered to them. A hand hygiene agent was noted to be on the snack cart but was being used by the PSW for themselves. The PSW stated they would provide hand hygiene only after a resident completes their snack, not before. DOC #100 clarified that the expectation would be that the PSW would be giving residents hand hygiene before they receive their snacks.

On another date, the inspector observed PSW #112, #113 and #114 providing snacks to residents on two units. The PSWs were not seen providing any hand hygiene to residents. Afterwards, when interviewed by the inspector, the PSWs acknowledged that they need to provide residents with hand hygiene before they receive their snacks, if the resident was capable of eating on their own. IPAC Lead #104 confirmed this process as well.

Failure to provide residents hand hygiene before eating their snack may result in residents developing infectious diseases.

Sources: Observation on various units on two dates; Interview with PSW #111, #112, #113, #114, IPAC Lead #104 and DOC #100. [760]

ii). The licensee has failed to ensure that Registered Practical Nurse (RPN) Student #108 performed hand hygiene after giving resident #002 their medication.

In accordance to the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard), under section 9.1, the four moments of hand hygiene shall be followed as per the licensee's IPAC program.

Rationale and Summary:
During an observation in the dining room, RPN Student #108 was seen providing a medication to resident #002. Afterwards, the RPN student proceeded to document the medication they provided to the resident on the iPad without performing any hand hygiene. RN #107, who was overseeing the medication pass, indicated that hand hygiene should be performed before documenting information into the iPad. DOC #100 confirmed that the expectation would be for staff to adhere to the four moments of hand hygiene, which includes performing hand hygiene right after administering a resident's medication.

Failure to follow the four moments of hand hygiene may lead to further spread of infectious diseases.

Sources: Observation on a dining room unit; Interview with RN #107, DOC #100 and other staff. [760]

This order must be complied with by April 24, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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.