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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 14, 2018	2018_378116_0002	028312-17	Critical Incident System

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

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 23, 24, 25, 26, 30, 2018.

This critical incident inspection was conducted in relation to an incident that caused an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Associate Director of Care (ADOC), registered staff members, personal support workers (PSW) and administrative support staff members.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **1 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident.

On an identified date, the licensee submitted a critical incident system (CIS) report to the Director reporting an incident that caused an injury to a resident for which the resident is taken to the hospital. The CIS read as follows:
On an identified date, resident #001 was observed exiting the home and sustained a fall. The resident was transferred to the hospital and returned the same day with an identified injury.

On a subsequent date, the licensee amended the CIS to inform the Director that, resident #001 was transferred to the hospital for further assessment and passed away due to identified diagnoses.

Review of progress note for an identified date, documented that resident #001 returned from the hospital with a confirmed injury. The physician on call was informed of the resident's return and ordered an identified medication to be administered along with directing staff to notify the physician after a specified time period if the medication is ineffective.

Review of the progress notes for an identified period, documents that resident #001 exhibited symptoms upon return to the home. An identified symptom was managed with medication as per the physician's order. Further notes on the same date, report that the resident continued to display symptoms related to an identified injury over the duration of an identified period.

Interviews held with registered staff member #'s103, #104 and #105, who were assigned to resident #001 between the identified period, indicated that the presentation of resident #001 was not within the resident's normal pattern. The registered staff indicated that they continued to monitor the resident over a specified period, and indicated that there was no further direction or planned care for the resident to respond to the resident's notable decline in health status.

Upon review of the progress notes and physician's orders, it was discovered that the direction for management of resident #001 was specific to an identified assessment related to the identified injury. There was no direction provided to staff on steps to

monitor for significant changes/marked decline within the health condition of resident #001 and the planned care for the resident.

Additionally, O. Reg 79/10, s. 49 (1) requires the home's 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 regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

An identified policy of the licensee which, falls under the falls prevention program directed staff to initiate a specified assessment on any resident who has sustained or is suspected of sustaining an identified injury, and after any unwitnessed fall. The policy directs staff to do the following:

- Complete the required assessment as per the schedule outlined or as ordered by the physician.
- Report any deviations from the baseline vital signs, Glascow coma scale, and/or level of cognition/consciousness immediately to the physician.

Review of an identified assessment record and interview with the ADOC indicated that the required assessment is to be conducted over scheduled increments and documented.

Review of resident #001’s health record and interviews held with registered staff #’s 103, #104 and #105 could not substantiate whether the required assessment was initiated after the resident fell on the identified date, and changes within the resident status reported to the physician.

Further interviews held with the E.D. and the ADOC acknowledged that the licensee failed to ensure that the written plan of care for resident #001 set out, the planned care for the resident when the health condition declined over an established period.

The severity of this finding was determined to be a level 4 as actual harm was sustained by resident #001
The scope of the issue was a level 1 and is isolated, as it resulted in harm of one resident. Review of the home's compliance history revealed that it was level one as there are no outstanding findings issued under s.6 (1) (a).

2. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

On an identified date, the licensee submitted a critical incident system (CIS) report to the Director reporting an incident that caused an injury to a resident for which the resident is taken to the hospital. The CIS read as follows:

On an identified date, resident #001 was observed exiting the home and sustained a fall. The resident was transferred to the hospital and returned the same day with an identified injury.

On a subsequent date, the licensee amended the CIS to inform the Director that, resident #001 was transferred to the hospital for further assessment and passed away due to identified diagnoses.

Review of resident #001's written plan of care revised on an identified date, indicated that the resident had identified behaviours that directed staff to be aware of the resident's whereabouts. The written plan of care did not establish a set frequency for staff to monitor the whereabouts of resident #001.

Upon review, resident #001 was identified on the home’s list of residents with an identified behaviour which is kept in specified locations.

Interviews held with staff member #’s 101, #102, #103, #104, #105 and #106 indicated being aware of resident #001’s normal routine and the requirement to be aware of the resident's whereabouts.

Review of the resident's heath record, the homes internal investigation notes and interviews with the above mentioned staff members along with management and administration staff of the home could not substantiate how resident #001 managed to exit the home unsupervised.

Further interviews held with the E.D. and the ADOC confirmed that the written plan of care did not set out clear directions to staff and others who provided direct care to resident #001 related to monitoring the whereabouts of resident #001. [s. 6. (1) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 22nd day of February, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAN DANIEL-DODD (116)
Inspection No. / No de l'inspection :	2018_378116_0002
Log No. / No de registre :	028312-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 14, 2018
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Weston Terrace Care Community 2005 Lawrence Avenue West, TORONTO, ON, M9N-3V4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michael Bastian

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, c. 8, s. 6 (1) a. Specifically, the licensee shall ensure the following is in place for all residents in the home.

Upon receipt of this compliance order the licensee shall develop a plan to ensure that the written plan of care for each resident sets out the planned care for the resident upon transfers and return(s) from hospital. The plan must include but is not limited to:

1. Develop procedures to ensure that all staff are made aware of when and how to notify physician(s) or respective parties of a significant change in status of residents.
2. Develop procedures to ensure that all staff are made aware of how to document the planned care for the resident.
3. Provide education and/or re-education on the identified assessment policy/procedure and identifying significant change of status in residents.
3. Review the identified home policy to indicate:
i) Duration of required procedure following an identified injury.
ii) Clarify the initiation of the identified procedure following the transfer of a resident or return from hospital after an identified injury.
3. Identify the responsible person(s) for each task.

Grounds / Motifs :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident.

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Upon review of the progress notes and physician's orders, it was discovered that the direction for management of resident #001 was specific to an identified assessment related to the identified injury. There was no direction provided to staff on steps to monitor for significant changes/marked decline within the health condition of resident #001 and the planned care for the resident.

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management program, must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

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Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 14th day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : SARAN Daniel-Dodd

Service Area Office / Bureau régional de services : Toronto Service Area Office