Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

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

Division des opérations relatives aux 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 30, 2019	2019_751649_0021	014164-19, 017729-19, 018628-19, 020754-19, 022051-19	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

JULIEANN HING (649), JOY IERACI (665)

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): November 13, 14, 15, 18, 19, 20, 21, and off-site November 25 and 26, 2019.

Logs #018628-19/ CIS #2874-000032-19, #017729-19, #020754-19/ CIS #2874-000035-19 related to medication management system.
Log #022051-19/ CIS 2874-000037-19 related to obtaining and keeping drugs.
Log #014164-19 related to falls prevention and management, weight changes, dealing with complaints, pain management, and plan of care.

During the course of the inspection, the inspector(s) spoke with director of care (DOC), assistant directors of care (ADOCs), nurse manager (NM), physiotherapist (PT), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), residents and family members.

A Voluntary Plan of Correction (VPC) related to O. Reg. 79/10 s. 8 (1) b was identified in this inspection report and have been issued in Inspection Report #2019_751649_0022, dated December 30, 2019, which was conducted concurrently with this inspection.

During the course of the inspection the inspectors reviewed residents' health records, staffing schedules, investigation notes, conducted observations related to the home's care processes and medication administration, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Nutrition and Hydration
Pain
Reporting and Complaints

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	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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 has failed to ensure that the care set out in the plan of care was based on an assessment of resident #001's needs and preferences.

A complaint was submitted to the Ministry of Long-Term Care (MLTC), related to concerns that resident #001's plan of care was not being followed.

A review of resident #001’s physiotherapy admission assessment indicated they required a mechanical lift for all transfer types. A lift and transfer assessment completed by the registered staff at admission indicated that the resident required a mechanical lift with an identified size sling.

According to the resident’s admission care plan under activities of daily living (ADLs) indicated for toileting they required a different type of lift and for transfers a mechanical lift. Based on the above mentioned assessments the resident was assessed to use only a mechanical lift for transfers and toileting, and was not assessed for the use of a different type of lift.

In an interview with RPN #106, who updated the resident’s care plan at admission to reflect the use of a different type of lift for toileting, told the inspector they were told by PSWs that was the type of lift they were using to toilet the resident. According to the RPN, when they updated the resident’s care plan, they were not aware that two different types of lifts should not be used for the resident.

In an interview with ADOC #100, they acknowledged that the resident’s plan of care

indicating to use a different type of lift for toileting was not based on the resident's assessed needs. [s. 6. (2)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A complaint was submitted to the MLTC, related to concerns that resident #001's plan of care was not being followed.

A review of resident #001's written plan of care under ADLs indicated that the resident required a different type of lift for toileting.

Observations by Inspector #649 on November 19 and 21, 2019, indicated that resident #001 was transferred from mobility aid to toilet using the mechanical lift.

In separate interviews with PSWs #109 and #113, they both acknowledged using the mechanical lift for the resident's toileting. PSW #113 explained during training they were told that the type of lift used to transfer a resident from bed to mobility aid or visa versa should be the same type used to toilet the resident.

In separate interviews with RPN #108 and ADOC #100, they both acknowledged that the resident's plan of care was not followed when staff used the mechanical lift for toileting the resident. [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 the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, and 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The home has failed to ensure that the Director was informed of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

The home submitted two critical incident system (CIS) reports to the MLTC, for a missing or unaccounted controlled substance for resident #011.

A review of the first CIS report indicated that an identified controlled medication was discovered not given to resident #011 on an identified date. The CIS report was submitted to the MLTC two weeks after it was discovered.

A review of a subsequent CIS report indicated that the resident’s identified controlled medication was discovered to be unaccounted for during a drug destruction, by the home’s pharmacist and NM #114. The CIS report was submitted to the MLTC three days later.

In an interview, DOC #121, indicated that both CIS reports should have been reported to the MLTC immediately or on the next business day.

This non compliance was issued as a result of the home’s failure to report to the Director, a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident. [s. 107. (3)]

2. The home has failed to ensure that the Director was informed of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, and make a report in writing to the Director setting out the following with respect to the incident, a description of the individuals involved in the incident, including, names of any staff members or other persons who were present at or discovered the incident.

A review of two CIS reports related to missing identified controlled medications for resident #011, indicated that the home conducted an investigation of each incident. The CIS reports did not include the names of the staff involved who received disciplinary action and education.

In an interview, ADOC #100 indicated that they were aware that the names of individuals were to be included in the CIS reports. The ADOC stated that they should have amended the reports to include the names of the registered staff involved in the CIS reports noted above.

In an interview, DOC #121 acknowledged the names of the registered staff were not documented in the two critical incident reports. [s. 107. (4) 2.]

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 Director was informed of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4) and within 10 days of becoming aware of the incident, or sooner if required by the Director, and make a report in writing to the Director setting out the following with respect to the incident, a description of the individuals involved in the incident, including, names of any staff members or other persons who were present at or discovered the incident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #011 in accordance with the directions for use specified by the prescriber.

The MLTC received complaints through the ACTIONLine related to missing identified controlled medications for resident #011. In an interview, the complainant indicated that they were notified by the home on two identified dates that the identified controlled medication was not found.

The home submitted two CIS reports related to missing identified controlled medications for resident #011 that occurred on two identified dates. Review of the first CIS report, indicated that at an identified time, RPN #129 checked for the resident’s identified controlled medication but did not find it. The second CIS report indicated that at identified

time, RPN #119 checked for the resident's identified controlled medication but it was not found.

A review of the resident's electronic medication administration records (eMAR) for the same period indicated that the resident was prescribed an identified controlled medication to be administered at identified intervals. The eMARs also directed the registered staff to check that the identified controlled medication was in place at a scheduled time each shift.

A review of the progress notes in point click care (PCC) on an identified date, documented by RPN #129, indicated that an identified controlled medication was not given to the resident when they checked. The RPN documented that another dose of the same identified controlled medication was administered to the resident.

A review of the home's investigation notes indicated that RPN #118 was the day nurse who had worked prior to RPN #129. RPN #118 checked for the placement of the identified controlled medication during their shift and discovered that it was not given to the resident and did not inform the nurse manager.

In an interview, RPN #118, indicated that they discovered the identified controlled medication was missing, but forgot to inform the nurse manager. The RPN indicated that they were very busy that shift and had only worked on the unit on two to three occasions. When the evening RPN #129 called RPN #118 the same day, regarding the identified controlled medication, RPN #118 indicated that they told RPN #129 that the identified controlled medication was missing on the day shift, but, did not inform the nurse manager. RPN #118 confirmed that the resident did not receive their dose of the identified controlled medication.

2. A review of the progress notes in PCC on an identified date, indicated that RPN #119 checked for the identified controlled medication at an identified time, but discovered it was not given to resident #011. RPN #119 stated that they called the physician on-call in the morning, to inform them of the missing identified controlled medication, and that the resident did not have any side effects. The physician instructed the RPN to continue monitoring the resident and to call back if the resident needed the medication. The RPN indicated that the resident complained of a side effect to their family members, and they then contacted the on-call physician and received an order to administer another dose of the identified controlled medication. A review of the medication administration audit report indicated that a new dose of the identified controlled medication was administered

to the resident.

In an interview, ADOC #100 indicated that the home conducted an investigation and discovered that RPN #120, who worked the evening shift, removed the identified controlled medication instead of another prescribed medication.

In an interview, RPN #120 indicated that the resident had received two medications. The RPN stated that they did not know what the identified controlled medication looked like and removed it in error, instead of the other identified medication. The RPN indicated that the resident did not receive their dose of the identified controlled medication as prescribed, since they had removed it.

A review of the medication administration audit report for the above incident, indicated that RPN #120, removed the identified controlled medication believing it was the other medication.

In an interview, DOC #121 indicated that after the home's investigation of these two critical incidents, RPNs #118 and #120 were provided education on the home's policies. The DOC acknowledged that as a result of the missing prescribed medications, resident #011 was not administered the identified controlled medication dosage in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint.

A complaint was made to the MLTC alleging that the home is not responding to their concerns even though they were appointed as the resident's substitute decision-maker (SDM).

In an interview with the complainant, they referred to a complaint they made to the home in writing on an identified date, where they alleged a nurse was rude to them, and refused to share information about resident #001's medications before administering to them, even though they were appointed as one of the resident's SDM.

A review of the resident's chart indicated previously written and signed communication appointing the complainant as the resident's SDM, and to be included in notifications regarding the status of the resident.

A review of the home's complaints binder indicated a written complaint was reported by the complainant related to the above mentioned concern. Further review of this written complaint indicated it was verbally responded to by the home ADOC #100.

In an interview with ADOC #100, they acknowledged that this was the first time they were dealing with a written complaint and admitted to not responding to the complainant in writing within the required 10 days time frame. [s. 101. (1) 1.]

Issued on this 9th day of January, 2020

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

Original report signed by the inspector.