Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 23, 2021	2020_631210_0015 (A1)	005117-20, 016725-20, 016937-20, 018234-20, 018263-20	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

Amended by NITAL SHETH (500) - (A1)

Amended 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): September 25, 28, 29, 30, October 1, 2, 5, 6, 7 and 8, 2020.

During the course of the inspection, the following complaints were inspected:

-016725-20 related to falls prevention program;

-015670-20 related to improper care;

-016937-20 related to resident's hospitalization and change in health status. This inspection was conducted together with intake #005117-20; and

-018224-20 related to abuse. This inspection was conducted together with intake #018263-20.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assisstant Director of care (ADOC), Director of Environmental Services (DES), Food Service Supervisor (FSS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist (PT), and Personal Support Workers (PSWs).

The inspector performed observations of staff and resident interactions, provisions of care, reviewed residents' clinical records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of the original 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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that resident #018 was treated with respect and dignity by PSW #117 on a specified date.

Resident #018's care plan indicated that bedtime for the resident is anytime in the evening. The resident was able to go to bed by themselves when they feel sleepy and tired.

The PSW intentionally made resident #018 stay in their bed when they wanted to go out of their room. During the evening the staff member tried to keep the resident in their bed and raised their hand towards the resident. The inspector reviewed the video footages, observed the above-mentioned incident, and found the staff member being rough and disrespectful to the resident.

Sources: CIS report, resident #018's care plan, video footages provided by the Substitute Decision maker (SDM), interview with the SDM, interviews with PSW #112 and other staff. [s. 3. (1) 1.]

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 resident was treated with respect and dignity, to be implemented voluntarily.

WN #2: 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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #013 as specified in the plan.

A complaint submitted to MLTC, indicated that resident #013 had a fall on an identified date and time which caused an injury to the resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Interview with the family of resident #013 and review of the clinical record indicated that the resident was walking with a walker and sustained an unwitnessed fall on a specified date and time. At a later time during the day the resident was transferred to hospital because the health status changed. The resident died on a specified date as per the hospital report.

A review of resident #013's written plan of care indicated staff to ensure that the bed alarm is in place. At the time of the fall, the bed alarm was not in place.

Sources: CIS report, resident #013's clinical record and care plan, interviews with

PSW #106 and RN #108. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care of resident #013 was documented.

A complaint submitted to MLTC, indicated that resident #013 had a fall on a specified date and time which caused an injury to the resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Resident #013 was walking with a walker, and sustained an unwitnessed fall on a specified date and time. At a later time during the day the resident was transferred to hospital because the health status changed. The resident died on a specified date as per the hospital report. Interview with staff indicated the resident was checked two times at night.

Resident #013 was at risk for falls and was on a toileting schedule as an intervention to prevent falls. The resident required assistance by one person for toileting. The Point of Care (POC) documentation indicated the resident to be offered assistance with toileting every two hours during day, evening and night, whenever they are awake. The fields that were created for documenting the task were for two and three o'clock only. The documentation for toileting did not indicate every two hours assistance.

Sources: Resident #013's clinical record, flow sheets for the toileting schedule, interviews with registered staff and others. [s. 6. (9) 1.]

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 was provided to the resident as specified in the plan and the provision of the care set out in the plan of care of the resident was documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #013 has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A complaint submitted to MLTC indicated that resident #013 had a fall on a specified date and time which caused an injury to the resident and resulted in hospitalization and a change in the resident's health status.

Resident #013 was using a walker for mobility. On a specified date the resident sustained an unwitnessed fall. At a later time during the day the resident was transferred to hospital because the health status changed. The resident died on a specified date as per the hospital report.

A review of resident #013's post fall assessment form, the home's investigation notes and interview with DOC and ADOC indicated the registered staff who found the resident on the floor during the last fall, performed assessment of the resident but did not initiate the head injury routine (HIR) form right away, but two hours later. Staff did not comply with the home's Fall Prevention and Management policy. Specifically staff did not perform a HIR until two hours after the resident fell. The post fall assessment was not performed according to the home's policy.

Sources: CIS report, Falls Prevention Policy #VII-G-30.10, dated February 2020, resident #013's clinical record, interviews with the DOC and other staff. [s. 49. (2)]

Issued on this 23rd day of July, 2021 (A1)

[redacted]

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

Original report signed by the inspector.