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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date May 24, 2022
Inspection Number 2022-1359-0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Sienna Senior Living Inc.

Long-Term Care Home and City
Weston Terrace Care Community

Lead Inspector
Slavica Vucko (210)

Inspector Digital Signature
Slavica Vucko
Digitally signed by Slavica Vucko
DN: cn=Slavica Vucko, o, ou, email=slavica.vucko@ontario.ca, c=CA
Date: 2022.06.02 13:49:49 -04'00'

Additional Inspector(s)
Adelfa Robles (723)

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 27-29, May 2- 6, 2022.

The following intake(s) were inspected:

- Intake # 002471-22 (Critical Incident System (CIS) report) related to potential neglect and nursing program
- Intake # 002021-22 (Complaint) related to hazardous substances and personal care
- Intake # 001182-22 (Complaint) related to multiple concerns

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

- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Quality Improvement
- Recreational and Social Activities
- Resident Care and Support Service
- Residents' and Family Councils
- Responsive Behaviours
- Safe and Secure Home

- Staffing, Training and Care Standards

INSPECTION RESULTS

There were *findings of non-compliance*.

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

Non-compliance with: O. Reg. 79/10, s. 91

The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

Rationale and Summary
On a specified date, the home's programs department organized Santa's gift stockings and provided them to residents, with a virtual presentation. The stockings contained a variety of items including a Snuggle gel air-freshener, which was to be kept out of reach of children. The air-freshener containers were not opened, and residents were not exposed to the contents.

The home removed all air-fresheners immediately after they learned of the potential hazard, and no residents were affected.

Sources: Interviews with staff, review of a family member and Family Council complaints. (210)

WRITTEN NOTIFICATION PLAN OF CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, *s. 6 (7)*

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

Rationale and Summary

A resident was unable to perform a specific personal care activity and required one team member assistance several times a day.

Several complaint emails were received by the home from the family related to the resident's personal care.

One staff provided the aforementioned personal care assistance to the resident on a specified date, only one time during the shift. The staff did not assist the resident with personal care later in the day because a family member was with the resident.

The Director of Care (DOC) stated that staff were expected to provide assistance with the personal care activity as specified in the resident's plan of care, unless agreed with the family member and documented.

Failure to provide personal care could result in poor hygiene and increased risk of infections.

Sources: Resident's written plan of care and interview with staff**.**
(723)

WRITTEN NOTIFICATION PLAN OF CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 , *s. 6 (5).*

The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
On a specified date, a resident had a medical emergency and passed away.

The resident's Health Care Wishes indicated if nearing death they wound want their family present.

Registered staff and the DOC acknowledged that the resident's SDM was not informed when the resident started to decline, and was informed after the resident passed away.

Failure of the home to provide opportunity for the resident's SDM to participate in the implementation of resident's plan of care resulted in a missed opportunity for the resident to fulfill their health care wishes at the end of their life.

Sources: Resident 's clinical record, interviews with staff and the DOC.
(723)

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, *s. 24 (1).*

The licensee has failed to immediately report to the Director when they had reasonable grounds to suspect improper or incompetent treatment or care that resulted in harm or risk of harm to resident #009.

Rationale and Summary

A CIS was submitted to the Ministry of Long-Term care (MLTC) on a specified date, regarding an incident that happened a month earlier, when a resident had a medical emergency and passed away.

The DOC and another team member conducted an investigation, and staff were interviewed two weeks after the incident.

The DOC stated that the home suspected improper treatment of the resident and submitted the CIS report. It took a while for the home to gather information, and the CIS was submitted as soon as they substantiated the allegations.

Sources: Home's investigation notes and interview with the DOC.
(723)

COMPLIANCE ORDER [CO#01] [LTCHA, 2007PLAN OF CARE

NC#05 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: LTCHA, 2007, *s. 6 (4) a*

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (b) prepare, submit and implement a written plan for achieving compliance with a requirement under this Act. 2021

Compliance Plan [*FLTCA, 2021, s. 155 (1) (b)*]

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The Licensee has failed to comply with **LTCHA, 2007, *s. 6 (4) a.***

Specifically, the licensee shall prepare, submit and implement a plan to ensure the staff and others involved in the different aspects of care of residents who experience health status changes collaborated with each other in the assessment of residents so that their assessments were integrated and consistent with and complemented each other.

The plan must include but is not limited to:

-Review of roles and responsibilities of registered staff and the Nurse in Charge on every shift, specifically related to assessment of residents with health status change;

-A Reporting and Communication Protocol (for contacting the Physician, Management on call) related to assessment of residents who experience sudden health status change or unusual decline in their baseline health status;

-Education for Registered staff and Nurses in Charge about the above-mentioned reporting protocol;

-Records of the education provided, including the date, staff attendance and the individual who provided the education;

-An Audit Tool to monitor and document proper implementation of the Reporting protocol for one month or until 100% compliance is reached.

Please submit the written plan for achieving compliance for inspection [#2022-1359-0001] to Adelfa Robles, LTC Homes Inspector, MLTC, by email to TorontoSAO.moh@ontario.ca by May 31, 2022

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

Non-compliance with: LTCHA, 2007, *s. 6 (4) a*

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident so that their assessments were integrated and consistent with and complemented each other.

Rationale and Summary

A resident had a sudden change in their health status and passed away on a specified date.

The resident's code status was to attempt Cardiopulmonary Resuscitation (CPR) as per the resident's health care wishes.

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The resident's health status declined on a specified date. On the same day they presented with sign and symptoms that required treatment. The nursing staff initiated a treatment as per the nursing protocol. The resident was restless and periodically did not comply with the treatment. The In-Charge Nurse was informed two times. After the second notification, the In-Charge Nurse assessed the resident and intensified the treatment beyond the parameters of the nursing protocol. The ambulance was called, and CPR attempted. The resident passed away within a few hours after the initial signs and symptoms of health status decline.

Registered staff did not inform the Physician, the Registered Nurse (RN) in the building, or management on call about the sudden health status change of the resident.

Failure of staff and others to collaborate in the different aspects of the resident's care increased the risk of delayed treatment.

Sources: Resident's clinical records, interviews with registered staff, the Physician and DOC. (723)

This order must be complied with by: June 24, 2022

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The 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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

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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
email: 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.