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
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Original Public Report

Report Issue Date: February 6, 2024	
Inspection Number: 2024-1359-0001	
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 Nrupal Patel (000755)	**Inspector Digital Signature** Nrupal Patel Nrupal Patel 2024.02.08 10:41:08 -05'00'
Additional Inspector(s) Christine Francis (740880) was present during this Inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 26, 29-30, 2024.

The following intake(s) were inspected:

- Intake #00099363 - Critical Incident System (CIS) # 2874-000042-23 - related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary:

A specific falls prevention intervention was observed on resident's wheelchair while they were up in their wheelchair. A review of the resident's clinical records indicated that the specific intervention was not documented in their care plan.

Registered Practical Nurse (RPN) acknowledged this intervention was not stated in resident care plan.

The Associate Director of Care (ADOC) acknowledged that the use of the specific intervention should have been included in resident's care plan.

The resident's care plan was revised on the same day to include the specific intervention for falls prevention.

There was no risk identified when the resident's care plan was not revised as the specific intervention had been used by the resident.

Sources: Observations; Resident's clinical records; interviews with RPN and ADOC.

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Date Remedy Implemented: January 29, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that a specific intervention was provided to resident as stated in their plan of care.

Rationale and Summary:

The resident's clinical records indicated they were at high risk for falls and were required to use a specific intervention at all times.

The resident was observed not using the specific intervention while in the wheelchair. The Personal Support Worker (PSW) acknowledged that they did not apply the resident's specific intervention.

RPN confirmed that the resident was required to use the specific intervention at all times as per their care plan.

The ADOC acknowledged that staff should have adhered to the resident's care plan and applied the specific intervention.

Failure to apply the specific intervention to the resident put them at risk of increased injury in the event of a fall.

Sources: Observations; Resident's clinical records; interviews with RPN, PSW and ADOC.

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