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: July 30, 2024

Inspection Number: 2024-1359-0003

Inspection Type:
Critical Incident (CI)
Follow up

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Weston Terrace Community, Toronto

Lead Inspector	**Inspector Digital Signature**
Manish Patel (740841)	Manishkumar C Patel Digitally signed by Manishkumar C Patel Date: 2024.08.01 13:25:11 -04'00'

Additional Inspector(s)
Trudy Rojas-Silva (000759)
Rachel Dioquino (000856)
Audra Sayn-Wittgenstein (000853)
Emily Rong (000827)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 23 - 26, 2024.

The following intake(s) were inspected:

- Intake: #00111098 was related to follow-up compliance Order #001 from Inspection #2024-1359-0002 related to O. Reg. 246/22, s. 102 (2) (b) with compliance due date: April 24, 2024.
- Intake: #00112304 / CI #2874-000019-24 was related to unexpected death of a resident.

- Intake: #00119489 / CI #2874-000040-24 was related to disease outbreak.
- Intake: #00115607 / CI #2874-000028-24, Intake: #00115878 / CI #2874-000031-24 and Intake: #00120069 / CI #2874-000043-24 were related to a fall with injury.

The following intake(s) were completed in this inspection:

- Intake: #00113441 / CI #2874-000021-24 and Intake: #00116384 / CI #2874-000032-24 were related to disease outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1359-0002 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Trudy Rojas-Silva (000759)

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The licensee has failed to ensure that the effectiveness of a fall prevention intervention was assessed with different approaches considered in the revision of a resident's plan of care.

Rationale and Summary:
A resident was observed in the TV room area with a specific falls prevention intervention that was not in use. The resident removed the falls prevention intervention multiple times after staff attempted to reapply during the observation.

Upon review of the resident's plan of care, it was indicated that the resident should have had a specific falls prevention intervention in place and that the resident required reminders to keep the intervention in place as they would remove it. Registered Practical Nurse (RPN) acknowledged that the resident often removed the falls prevention intervention and that the intervention should have been reassessed.

Failure to reassess the effectiveness of fall prevention interventions and consider

different approaches to revise the resident's fall related plan of care increased the risk of falls.

Sources: Observation; interview with RPN; and resident's clinical records.

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The Licensee failed to ensure that when a resident had an altered skin condition, they received a skin assessment by an authorized person, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary:
A resident sustained a skin alteration after an incident.

Upon review of resident's clinical records, it was identified that a skin assessment was not completed for the skin alteration after an incident. RPN acknowledged that they did not complete a skin assessment for the skin alteration and that they should have completed an assessment after the incident.

Failure to complete a skin and wound assessment after the incident, increased the risk for delayed interventions and management of the skin alteration.

Sources: Interview with RPN; and resident's clinical records.

WRITTEN NOTIFICATION: Maintenance services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee has failed to ensure that an equipment used for falls prevention intervention is kept in good repair for a resident.

Rationale and Summary:
A resident had a fall, resulting in an injury.

The resident was observed using their assistive device in their room.

Two Personal Support Workers (PSWs) assisted the resident to a standing position and it was noted that the equipment used, was not working when the resident stood up.

A PSW manipulated the equipment but failed to demonstrate that the equipment

was in working order. The PSW stated that the equipment was not working.

Failure to ensure the equipment used for falls prevention intervention was in good repair, resulted in an increased risk of fall and injury to the resident.

Sources: Observation of the resident, Interviews with PSWs.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 4.3 stated the licensee shall ensure that following the resolution of an outbreak, the Outbreak Management Team (OMT) and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices.

Rationale and Summary:
IPAC Lead informed inspector that once an outbreak in the home has been resolved, a debrief with the OMT and the interdisciplinary IPAC team is not conducted. IPAC Lead stated that for the three different outbreaks that were resolved earlier, a debrief session assessing the IPAC practices that were effective and ineffective in the management of those outbreaks, was not conducted. Nor could they provide a record of the summary of findings that makes recommendations to the licensee for improvements to outbreak management practices, once the outbreaks were resolved.

The home's failure to comply with conducting debriefs once an outbreak has been resolved, put the management of the infection prevention and control program at risk.

Sources: Interview with IPAC Lead, absence of outbreak resolution debrief records.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to ensure that the Director is immediately informed of an

unexpected or sudden death of a resident.

Rationale and Summary:
A resident was transferred to the hospital five days after admission in to the home. The resident passed away in the hospital and the home was informed of the resident's death five days after hospitalization.

Review of the after-hours report and Critical Incident indicated that the Director was informed of unexpected or sudden death two days after the home became aware of the unexpected or sudden death.

The Director Of Care (DOC) and Registered Nurse (RN) acknowledged that the sudden or unexpected death needed to be reported to the Director immediately and it was not reported immediately.

Sources: Review of after-hours and Critical Incident report, resident's progress notes; Interview of DOC and RN.