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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: December 1, 2023

Inspection Number: 2023-1056-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

Long Term Care Home and City: The Willows Estate Nursing Home, Aurora

Lead Inspector	**Inspector Digital Signature**
Elaina Tso (741750)	Elaina Tso Digitally signed by Elaina Tso Date: 2023.12.07 09:07:59 -05'00'

Additional Inspector(s)
Ana Best (741722)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 1 - 3, 6 - 10, 2023.

The following intake(s) were inspected:

- A complaint intake related to a resident's care and oxygen administration.
- Three intakes related to resident to resident physical abuse.
- An intake related to first follow up to Compliance Order (CO) #001, from Inspection #2023-1056-0002, FLTCA, 2021 - s. 6 (7) related to plan of care, Compliance Due Date (CDD) September 28, 2023.

- A complaint intake related a resident's safety due to co-resident's responsive behaviours.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2023-1056-0002 related to FLTCA, 2021, s. 6 (7) inspected by Elaina Tso (741750)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Continent care and bowel management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident who is incontinent, has an individualized plan as part of their written plan of care to manage their bowel and bladder continence.

Rationale and Summary
A complaint was made to the Director related to a resident's continence product not being changed before their medical appointment. The complainant further indicated that they were told by the staff at the medical center that the resident's continence product was full when they arrived for their appointment.

The resident had incontinence and required continence product. After the incident had happened on that specific date, the resident's Substitute Decision Maker (SDM) of care had made a request to the staff to change resident's continence product before they left for their medical appointment.

The resident's written care plan indicated to provide peri care after each incontinence episode. The care plan was updated to "change brief as needed". The care plan did not outline specific instructions to change the resident's continence product prior to their medical appointments.

A Personal Support Worker (PSW) indicated that the resident needed to be changed before their medical appointment. The PSW also confirmed that this instruction was verbally passed onto them by the registered staff and other colleagues as there was

no instruction in the resident's written care plan and Point of Care (POC).

An Registered Nurse (RN) indicated that the process was to have the PSWs change the resident two times per shift which included to change the resident continence product before they went to their medical appointment.

Failing to ensure there was an individualized written plan of care for the resident created misunderstanding and potential missed care by direct care staff.

Sources: resident's health records, interviews with the PSW and the RN. [741750]

WRITTEN NOTIFICATION: Conditions of licence

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
Licensee must comply
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with Compliance Order (CO) #001 from Inspection #2023-1056-0002, with a compliance due date of September 28, 2023.

Specifically, the required auditing process by a member of the management team or Registered Nurse was not fully implemented and the 15-minute safety checks documentations was not fully completed.

Rationale and Summary
A Critical Incident Report (CIR) was submitted to the Director related to a resident

who had a fall with injury. The home was subsequently issued a Compliance Order with a compliance due date of September 28, 2023.

The compliance order required the home to:
1) A member of the management team or Registered Nurse designate to implement an auditing process related to 15-minute safety checks documentation by all direct care staff for three residents. The audits will be conducted daily, including weekends and holidays, on all shifts for two weeks. Keep a documented record of the audits completed, dates of when the audits were completed, the names of the staff audited and what education was provided when documentation was not completed. Make this record available to inspectors immediately upon request.

2) A member of the management team or Registered Nurse designate to implement an auditing process related to application of hip protectors for a resident. The audit will be conducted daily, including weekends and holidays, on all shifts for two weeks. Keep a documented record of the audits completed, dates of when the audits were completed, the names of the staff audited and what education was provided when application of hip protectors was not implemented. Make this record available to inspectors immediately upon request.

The home's audit records on both the 15-minute safety checks documentation and the application of hip protectors showed more than 50 percent (%) of the audits were completed by the Registered Practical Nurses (RPNs). The Director of Care (DOC) confirmed that they had RPNs complete both audits. In addition, there were gaps identified in the 15-minute safety check documentations on a specific date during their two weeks' auditing period. The DOC confirmed the same.

There was potential risk to the resident as they were at risk of falls and not completing the 15-minute safety check documentations would prevent the home

from identifying and addressing the gaps.

Sources: CO #001 from Inspection #2023-1056-0002, home's audit records, resident's health records, and interview with DOC.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the

licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee has failed to ensure that an assessment was developed to meet the needs of residents with responsive behaviours. Specifically, the registered staff did not complete a comprehensive behavioural assessment upon a resident's admission to the Long-Term Care Home (LTCH).

Rationale and Summary

Two CIRs was submitted to the Director related to the inappropriate actions of a resident towards two other residents.

There was an assessment completed by the Home and Community Care Support Services prior to the resident's admission to the LTCH, identified they had different behaviours.

The LTCH's Supporting a Resident with Responsive Behaviours policy, identified that

the home's process was to complete a comprehensive behavioural assessment for each resident at the time of admission, and if it was determined that there was a history or risk of responsive behaviours, a referral to the Behavioral Supports Ontario (BSO) was to be initiated.

The BSO Lead indicated the home's process was to have the nursing staff initiate a Behavioural Supports Ontario Dementia Observation System (BSO-DOS) for five days, and a Violence Assessment Tool (VAT). The BSO nurse confirmed the DOS new admission documentation was incomplete.

The CCC indicated they had completed the VAT but not on admission.

The RAI coordinator indicated it was the home's process to complete a BSO referral form. The LTCH was unable to produce record related to completion of the BSO referral form on admission or record of the date of BSO referral for the resident.

Failure to ensure that a comprehensive behavioural assessment was completed for the resident at the time of the admission to the LTCH, increased the risk of not identifying the resident's behavior needs and required interventions.

Sources: resident's health records, LTCH's policy, interviews with the CCC, BSO Lead and RAI coordinator. [741722]