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

Public Report

Report Issue Date: December 20, 2024

Inspection Number: 2024-1056-0005

Inspection Type:
Critical Incident

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 9-12, 16, 18, 19, 2024
The inspection occurred offsite on the following date(s): December 13, 2024

The following intake(s) were inspected in the Critical Incident (CI) inspection:

- One intake was related to resident to resident physical abuse.
- Four intakes were related to improper care of a resident.
- One intake was related to staff to resident physical abuse.
- One intake was related to Falls prevention and management.
- One intake was related to an injury of a resident with unknown origin.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that a resident's right to privacy of health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential when signage was observed to be posted on the outside of the resident's door that communicated the resident's personal health information on a specific date.

Sources: Observations and interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written

plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that the written plan of care for a resident in relation to bathing activities set out clear directions to staff who provided direct care to the resident. On a specified date, the resident's care plan provided instructions regarding the level of assistance required for transferring and completing bathing activities while also simultaneously providing contradictory instructions. On another date, the resident's care plan provided contradictory instructions in relation to the bathing method for the resident. The DOC confirmed that the instructions outlined in the resident's care plan regarding the method of bathing and assistance levels for bathing activities were contradictory and unclear for staff to follow.

Sources: Health records for a resident and interview with the DOC.

WRITTEN NOTIFICATION: INTEGRATION OF ASSESSMENTS, CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff involved in physiotherapy services and nursing care collaborated in the development and implementation of a resident's plan of care in relation to falls prevention interventions. The resident's health records demonstrated that the home's physiotherapist (PT) recommended

interventions on specific dates and shared the interventions with nursing staff upon recommendation, however, the resident's care plan was not updated to reflect the use of the interventions until a specified date. One intervention was recommended but was not transitioned into the resident's care plan or implemented as an intervention. The DOC confirmed that there was a disconnect in the expected process, acknowledging that interventions were recommended but not entered into the care plan for the resident and thus not communicated to front line staff.

Sources: Health records for a resident, interviews with the PT and DOC.

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from verbal abuse by a Personal Support Worker (PSW).

Ontario Regulation 246/22, s. 2 (1) defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

A resident alleged improper care and inappropriate comments were made to them by staff. The PSW admitted in the Long-Term Care Home's (LTCH) investigation to verbal abuse towards the resident. The administrator confirmed that verbal abuse was substantiated from staff to the resident.

Sources: CIR, LTCH's investigation notes, PSW's staff record, interview with Administrator.

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

During an observation of the resident, they were seated on their assistive aid and a staff was observed pushing them on the assistive aid from the resident's room to the dining room. The resident's plan of care indicates they are at risk for falls and directs staff to ensure they use their assistive aid at all times.

The BSO Lead and the DOC acknowledged that this was not a safe practice, and that staff should have obtained a alternate equipment for the resident if they were unable to ambulate with their assistive aid.

Sources: Observation, resident's health record, interviews with BSO Lead and DOC.

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure the implementation of a fall intervention device for a resident on a specific date. The resident's care plan provided instructions for the implementation and use of the intervention. The resident was observed on a specified date without the intervention implemented.

Sources: Observation, health records for a resident, interviews with PSW staff and Registered Practical Nurse (RPN).

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident sustained a fall on a certain date, that a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls. The resident's health

records documented that a fall occurred on a specific date, however, a post-fall assessment was not completed.

Sources: Health records for a resident, post-fall assessments, interview with the DOC.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure the strategies developed to respond to a resident's behaviours were implemented by a PSW.

Specific interventions were in place for staff to use during care for a resident to manage responsive behaviours. A PSW was witnessed providing care to a resident in a manner the resident did not like which caused the resident to become agitated. The resident wanted to complete the task independently and was upset the PSW was not listening to them. A visitor had to intervene to deescalate the resident.

The DOC acknowledged that the PSW did not read and follow the plan for providing care to the resident.

Sources: Resident's health record, LTCH investigation notes, interview with DOC.

WRITTEN NOTIFICATION: HIRING STAFF, ACCEPTING

VOLUNTEERS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (2) (b)
Hiring staff, accepting volunteers
s. 252 (2) The police record check must be,
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee.

The licensee has failed to ensure that the police record check for a PSW was conducted within six months before the staff member was hired by the licensee. The police record check provided to the home for the PSW position was conducted on specified date. The DOC confirmed that the PSW was hired on a certain date and that the police record check was not conducted within the six months before the staff was hired.

Sources: Employee file for a PSW, police record check for a PSW, and interview with the DOC.

COMPLIANCE ORDER CO #001 Skin and wound care

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
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,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure the following:

1. The Director of Care (DOC) and/or the designated Skin and Wound Lead will provide in-person education to all registered staff, including agency staff, on both floors regarding the assessment and monitoring of residents who have been identified as having altered skin integrity. The in-person education must include what constitutes altered skin integrity, the expected process to assess a resident exhibiting altered skin integrity, as well as documentation of the assessment, including a description of the area/wound involved, the peri-wound skin, drainage, odour, measurements, including the length, width, depth, and any undermining or tunneling. The education must also include the expected use of the skin and wound app, including how to ensure appropriate measurements are taken and documented. A current list of the registered staff, including agency staff, is to be kept. Documentation of the education will include the date the education was provided, the content covered, the full name and designation of the individual(s) providing the education as well as of all participants. Documentation is to be kept and made immediately available to the Inspector upon request.

2. The DOC and/or the designated Skin and Wound Lead is to conduct weekly audits for four consecutive weeks, of all residents exhibiting altered skin integrity, including but not limited to any redness, bruising, skin tears and pressure injuries, to ensure that each resident identified as having altered skin integrity has been assessed at minimum weekly, and that the assessment includes a description of the wound, surrounding skin and measurements. Documentation of the audits will include the date of the audit, the name of the residents identified to have altered skin integrity, that the assessment is fully completed and documented in the expected manner, and note any corrective actions taken with staff. Documentation is to be kept and made immediately available to the Inspector upon request.

Grounds

1. The licensee has failed to ensure that a resident's altered skin integrity was reassessed on a weekly basis. An initial assessment of the resident's altered skin integrity was completed on a specific date. Altered skin integrity was identified but no further reassessments were completed. By not completing, at minimum, weekly skin and wound reassessments of the resident's altered skin integrity, opportunity for monitoring was missed, which could increase the resident's risk for pain, infection, or other complications not being addressed

Sources: Health records for a resident and interview with the DOC.

2. The licensee failed to ensure that when a resident was identified to be exhibiting altered skin integrity on a specific date, that the skin integrity concern was initially assessed as well as reassessed on a weekly basis following identification. There were no skin and wound assessments completed for the specific skin integrity concern within the resident's health care records. A Registered Nurse (RN) and the DOC confirmed that there were no assessments completed and that this identified skin integrity concern should have been reassessed weekly. Failure to complete an initial skin and wound assessment as well as subsequent weekly follow up assessments resulted in lost opportunity for monitoring the skin integrity concern, which placed the resident at increased risk for negative clinical outcomes, such as infection.

Sources: Health records for a resident, interviews with an RN and the DOC.

This order must be complied with by March 10, 2025

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

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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:

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
e-mail: 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.