Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 23, 2017 | 2016_324535_0009 | 034139-16 | Resident Quality Inspection |

## Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

## Long-Term Care Home/Foyer de soins de longue durée

Woodbridge Vista Care Community
5400 Steeles Avenue West Woodbridge ON L4L 9S1

## Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

VERON ASH (535), NICOLE RANGER (189)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): December 13,14, 15, 19, 20 ,21 ,22 ,23, 2016, January 3, 4, 5, 6, 2017.**

**The following critical incident (CI) inspections were conducted concurrently with the RQI: 032639-16 (related to fall with injury).**
**The following complaints were conducted concurrently with the RQI: 021170-16 (related to medication), 032963-16 (related to abuse).**
**The following follow ups were conducted concurrently with the RQI: 031810-16 and 001506-16/025563-15( illegal discharge).**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nurse Managers, Resident Assessment Instrument (RAI) coordinator, Registered Dietitian, Director of Quality, Family and Resident Services, Director of Programs, Director of Environmental Service (ESM), Housekeeping Supervisor, Registered Nursing Staff, Personal Support Workers (PSWs), maintenance worker, Residents' Council president and Family Council president, residents and family members (SDM).**

**During the course of the inspection, the inspectors(s): conducted a tour of the home; observed medication administration, staff to resident interactions and the provision of care, resident to resident interactions; and reviewed resident health care records, meeting minutes for Residents' Council and Family Council, and relevant policies and procedures.**

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

**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Admission and Discharge**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **11 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 148. (2) | CO #001 | 2016_378116_0006 | 535 |
| LTCHA, 2007 S.O. 2007, c.8 s. 6. (7) | CO #001 | 2016_405189_0008 | 189 |

## NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents**
**Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,**
**(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and**
**(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

On an identified date, the home submitted a Critical Incident System Report (CIS), reporting an allegation of resident to resident abuse.

Record review of resident #010's progress notes revealed eight incidents of altercations between resident #010 and resident #011.

Interview with RPN#127 revealed the interventions in place were to redirect and monitor resident #010 and resident #011.

Interview with nurse manager #123 revealed that on an identified date, resident #010's SDM approached him/her with a concern of the supervision of residents on the unit. The Nurse Manager informed the inspector that the staff were instructed to continue to monitor and supervise the resident.

Interview and review of the incidents with the Director of Care confirmed that based on the multiple incidents with resident #010 and resident #011, it is shown that resident #011 was a trigger for resident #010, however no additional interventions other than redirection and monitoring was in place to minimize the risk of altercations and potentially harmful interactions between the residents.

The severity of harm is actual harm.
The scope is isolated.
The compliance history is no previous non-compliance.

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 7. Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent. 2007, c. 8, s. 7.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #021 provided consent for care or services.

On an identified date, the MOHLTC received a complaint regarding medication being changed without consent for resident #021.

Record review revealed that on admission to the home on an identified date, resident #021 was listed as own power of attorney (POA) for personal care and financial care. However, on an identified date, resident #021 gave the home verbal consent to share information with family member #141.

A review of the extensive documentation in the progress notes showed that resident #021 engaged in multiple medical consultations with physician #139 from an identified time period which resulted in recommendations to change and/or adjust his/her medication.

On an identified date, resident #021's medication was changed, however resident #021's family member was not notified about the change in medication. The family member #141 reported that they inquired about the resident's medication and was told that the resident's medication was changed two months prior. The family member reported that the home changed the resident's medication without informing the family.

Multiple documented progress notes revealed that the resident was unable to make decision for his/her care and also requested the staff to contact the family member.

During an interview, the Director of Quality, Family and Resident Services #128 stated that the resident wanted all communications to him/herself and family member #141, and therefore family member #141 was the resident substitute decision maker.

During an interview with the home Executive Director #102, he/she stated that it would appear that the home's Behavior Support Ontario (BSO) nurse recommended changes to resident #021 medications without the family's consent.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are provided opportunity to consent for care or services, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home and equipment were maintained in a safe condition and in a good state of repair.

During stage one of the RQI, the inspectors observed the following concerns related to the maintenance of the home: On an identified date, the inspector observed in two identified rooms a panel from the heating radiator cover was missing which caused the exposure of sharp edges that could possibly cause an injury. In addition, an identified room was observed to have multiple scrapes and scratches on the left side of the wall and washroom door.

During an interview, RPN #108 stated that he/she was not aware that there was a panel from the heating radiator cover missing from the identified room; and while visiting the room he/she also confirmed that the left wall was in a state of disrepair with multiple scrapes and scratches.

During an interview, the maintenance worker #105 stated that he/she was currently working to restore and paint rooms which were vacant so that new residents would be admitted into new and freshly painted rooms. He/she also stated that the home had recently changed the color used for painting residents' rooms; and the previous paint was no longer available.

An interview with the Director of Environmental Services #117 (ESM), confirmed that the home had introduced a new standard color for all residents' rooms and that they have already repainted many areas in the home. He/she also confirmed that there were rooms to be repaired and painted, including the identified room; but that he/she preferred to complete the repairs on the full room versus fixing the wall with a different color.

The Director of ESM's expectation was that the maintenance team coordinate their effort and find the time needed to complete room repairs while working on remodeling and painting rooms which were vacated by previous residents; and that the heating radiator panels were immediately replaced in both rooms by the maintenance worker.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviors, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

On an identified date, the home submitted a Critical Incident System Report (CIS) to the MOHLTC, reporting an allegation of resident to resident abuse

Record review of resident #011's progress notes revealed that on nine identified dates, resident #011 demonstrated responsive behaviors.

Interview with RPN #127, RPN #126 and RPN #136 revealed that for a resident exhibiting new or change in responsive behavior, a Dementia Observation System (DOS) tracking tool would be initiated and the resident wound be referred to and assessed by the Behavioral Support Ontario (BSO) nurse. Record review with registered staff confirmed that resident #011 was not seen by the BSO nurse for reassessment, since her last visit on an identified date, and a referral for the resident's behaviors to the BSO nurse was not completed.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident demonstrating responsive behaviors, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

On an identified date, the MOHLTC received a complaint regarding medication error for resident #021.

Record review showed that resident #021 was readmitted to the home on an identified date and time. On an identified date, the resident's faxed prescription from the medical facility listed an identified medication to be given at an identified time for one week. The home's new admission form from Medi-system was completed by the RN on an identified date, and showed the same as was listed in the fax prescription, However, the record also showed that another fax was received from the social worker at the medical facility on an identified date which indicated that the resident received his/her medication at a 08:30. Resident #021 missed his/her dose of the identified medication at bedtime because the registered staff and the charge nurse on duty were both unsure whether '08:30' indicated a morning or evening administration time.

During an interview registered staff RPN #136 stated that on the identified evening shift he/she was not able to verify whether the medication was last administered during the morning or previous evening shift. The registered staff also stated that they asked the resident if he/she had received the medication and the resident stated that he/she had already received medications earlier that day before discharge from the medical facility. The staff confirmed that they did not want to give the resident a double dose of medication; therefore the nurse manager informed the registered staff to hold the medication, which caused the missed dose.

During an interview the day nurse manager #132 revealed that on an identified date, he/she discovered the error in missing dose and confirmed that the evening manager informed registered staff RPN #129 to hold the medication to prevent double dosing the

resident. Nurse manager #132 and the DOC confirmed with the medical facility that the medication was to be administered in the evening. The nurse manager also confirmed that on an identified date he/she had to enter the identified medication into the medication management system manually; and recalled that the sticker on the medication showed that it was to be administered at bedtime, however the evening staff missed the bedtime administration instruction written on the medication.

During an interview, DOC #103 stated that the medication incident was bought to him/her attention the next day on an identified date and that the registered staff and nurse manager should have contacted the physician and/or manager on call to provide support for their decision to hold the medication. He/she also confirmed that the resident should have received the medication as prescribed on the identified date at bedtime.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

On an identified date and time, the inspector was in the hallway on an identified floor and observed the shower room door wide open, with the privacy curtains slightly closed. Resident #012 was observed inside the shower room.

Interview with PSW #120 who was providing the resident a shower, stated that he/she left the shower room door open as there is an odor in the shower room. Interview with RPN #122 revealed he/she did not receive any reports from staff related to odors in the shower room. Record review of the maintenence log from an identified time period did not identify reports of concerns of odor in the shower room.

Interview with the Executive Director revealed that it is the PSW's common practice in the home to have the privacy curtain closed and shower door open while the resident is having a shower. The Executive Director confirmed that the home's expectation is for the shower door to be closed and to provide privacy to residents when providing care.

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

On an identified date, during a review of resident #005's Medication Administration Record (MAR), the inspector observed a written medication error.

Interview and review of the resident MAR with the DOC confirmed the written discrepancy on the MAR and an incident report was sent to the pharmacy to review. The DOC provided the inspector the pharmacy incident report which revealed the data entry error from the pharmacy.

Review of the Medi-System pharmacy policy " Ordering and Receiving medications" revised June 23, 2014, states upon receipt of the medication nurses or facility authorized care providers must check all printed packing lists for correctness with the medication received, make appropriate corrections and inform pharmacy of any discrepancies. Interview with the DOC confirmed that the registered staff should verify the all information on the eMAR for accuracy.

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

**s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
**(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident-staff communication and response system was easily accessed and used by residents, staff and visitors at all times in room #234.

During stage one of the RQI, the inspector observed that the call bell system in resident # 022's washroom was non-functional. The top portion of the call bell which normally slides in the downward position by pulling on the cord to activate the light and sound was pushed upwards in a hyper-extended position above the top of the base; which caused the call bell to become immobile or jammed in the upward position.

The inspector alerted a PSW of the situation, and PSW #106 successfully replace the hyperextended portion of the call bell back to the normal position by gripping tightly to the top portion which was stuck in the upwards position, and pulling downwards with significant force which snapped the top portion of the call bell back in the normal, functional position. After testing the call bell to ensure it was functional again, the PSW stated that he/she had not witnessed this situation before.

During an interview with PSW #107, he/she stated that they were the primary care-giver on the evening shift for resident #022. The PSW continued by stating that the resident

was alert but cognitively impaired; and that whenever he/she toileted the resident and was standing at the washroom door, the resident would still activate the call bell. The PSW further stated that even while providing care for the resident inside the room, he/she would still try to activate the call bell.

The inspector attempted to interview resident #022; however although alert, the resident was not able to answer questions related to his/her ability to access and activate the call bell in their room.

During an interview, the Maintenance Worker #105 stated that the call bell was put in that non-functional position by someone other than the residents who resided in room; and that this practice was unacceptable. He/she further stated that they had seen similar situations with the call bell in residents' rooms in the past; but that the incidents were reported to the previous Maintenance Manager. The Maintenance worker also stated that he/she had not seen this situation for a while since the issue was previously addressed by the nurse managers. He/she further stated that it was not acceptable to have the call bell in that condition because the residents in the room would not be able to call for help if needed.

During an interview with RPN #108, he/she stated they had not seen or heard of this situation with the call bell before and that the call bell in residents' rooms should be in working condition at all times.

During an interview, the Director of ESM stated the expectation was that call bells should be in working condition in residents' rooms at all times.

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that for a resident who was incontinent received an assessment that includes: identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Record review and staff interview revealed that resident #003 was hospitalized on an identified date, and return back to the home on an identified date, with a medical treatment.

Interview with RPN #100 revealed that upon readmission from hospital, or if there is a significant change in condition that impact bladder and bowel functioning, a continence assessment is required.

Record review of the continence assessments for resident #003 revealed that continence assessment on an identified date were not conducted.
Interviews with RPN#142 and the RAI Coordinator #100 confirmed that the continence assessments were not conducted for the identified date for resident #003.

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

**Specifically failed to comply with the following:**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:**
**(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,**
**(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and**
**(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that procedures were developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assisstive aids and contact surfaces.

During stage two of the RQI, resident #001 and #002 both triggered for unclean ambulatory equipment.

On an identified date, the inspector observed resident #001's wheelchair was unclean and visibly soiled. During an interview, PSW #135 confirmed that the resident's wheelchair was soiled; and the resident was transferred to the hospital for an illness, and since return to the home the wheelchair may not have been added to the cleaning schedule.

The inspector reviewed the home's walker and wheelchair cleaning schedule which was also confirmed by PSW #135. The schedule indicated that evening PSWs were to place walkers, wheelchairs and geri-chairs in the hallway before the end of the shift; and that night PSW were to wash and clean walkers, wheelchairs and geri-chairs before 0300 hours. The cleaning schedule rotated according to residents' rooms on different days of

the week.

During interviews, registered staff RPN #136 and RN #137 both confirmed the details of the cleaning schedule above; and registered staff RPN #136 added that even if the wheelchair was not scheduled for cleaning, whenever the wheelchair was observed to be soiled, PSWs should be cleaning the wheelchairs as needed. Both staff also agreed that resident #001 wheelchair should have been cleaned and disinfected.

On two identified dates, the inspector observed that resident #002's floor mat was unclean and visibly soiled. Interviews were conducted with multiple staff with differing information shared with regards to the cleaning of floor mats in the home: PSW #138 stated that floor mats were cleaned on an as needed basis when they proceeded to remove the protective cover from resident #002's floor mat and sent it to the laundry room for cleaning. PSW #113 stated that floor mats were scheduled to be cleaned on resident's shower days; and therefore at least twice weekly floor mats were to be cleaned. He/she further stated that the written cleaning schedule was no longer posted on the units but that PSWs were aware of the schedule. Registered staff #115 stated that there was no current schedule or policy available for cleaning resident's floor mats. All staff who were interviewed acknowledged that the resident's floor mat was unclean; and that it should have been cleaned by a PSW whether it was scheduled or not.

During an interview with the DOC #103, he/she stated that the expectation was that resident's wheelchairs were cleaned as scheduled and as needed by all PSWs on every shift and not just the night shift. He/she further stated the expectation was that housekeeping staff and/or PSWs should check residents' floor mats and if soiled; either group should clean the floor mat or remove the protective cover and send to the laundry for cleaning. The DOC also confirmed that the home did not have a cleaning schedule or policy to guide practice for cleaning resident's floor mats.

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

**Specifically failed to comply with the following:**

**s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that as part of the organized program of maintenance services, there were schedules and procedures in place for routine, preventive and remedial maintenance.

During stage one of the RQI, the inspectors observed the following concerns related to the maintenance of the home: On an identified date, the inspector observed that an identified room had multiple scrapes and scratches on the left side wall and on the washroom door.

During an interview, registered staff RPN #108 confirmed that the left wall was in a state of disrepair with multiple scrapes and scratches. During an interview, the maintenance worker #105 stated that he/she was currently working to restore and paint rooms which were vacant so that new residents would be admitted into new and freshly painted rooms; but did confirm that the wall in the identified room was in a state of disrepair. He/she also stated that the home had recently changed the color used for painting residents' rooms; and the previous paint was no longer available.

An interview with the Director of Environmental Services #117 confirmed that there were rooms to be repaired and painted, including the identified room; but that he/she preferred to complete the repairs on the full room versus painting the wall with a different color.

**Issued on this 24th day of February, 2017**

**Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs**

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

**Ministére de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

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| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | VERON ASH (535), NICOLE RANGER (189) |
| **Inspection No. / No de l'inspection :** | 2016_324535_0009 |
| **Log No. / Registre no:** | 034139-16 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Feb 23, 2017 |
| **Licensee / Titulaire de permis :** | 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP<br>302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | Woodbridge Vista Care Community<br>5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Kerri Judge |

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

**Order / Ordre :**

The licensee shall prepare and submit a plan to ensure that any identifying factors or triggers are identified and steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

The plan shall include, but limited to the following:

Ensure that resident #10, resident #011, and all residents of the home demonstrating responsive behaviors have interventions in place to minimize potentially harmful interactions between residents

When responsive behaviors are exhibited by a resident, that the resident is assessed by members of the Behavior Support Ontario (BSO) team as required, and based on an interdisciplinary assessment will identify factors that could potentially trigger such altercation.

Ensure that residents demonstrating responsive behaviors are identified with strategies to direct staff in the management of the behaviors in each resident's plan of care.

Provide education to all staff that enables them to recognize potential triggers and factors of responsive behaviors demonstrated by residents.

The licensee shall maintain a record of re-training provided including dates, times, attendees, trainers and material taught.

The Plan is to submitted by email to nicole.ranger@ontario.ca by March 10, 2017

**Grounds / Motifs :**

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Record review of resident #010's progress notes revealed eight incidents of altercations between resident #010 and resident #011.

Interview with RPN#127 revealed the interventions in place were to redirect and monitor resident #010 and resident #011.

Interview with nurse manager #123 revealed that on an identified date, resident #010's SDM approached him/her with a concern of the supervision of residents on the unit. The Nurse Manager informed the inspector that the staff were instructed to continue to monitor and supervise the resident.

Interview and review of the incidents with the Director of Care confirmed that based on the multiple incidents with resident #010 and resident #011, it is shown that resident #011 was a trigger for resident #010, however no additional interventions other than redirection and monitoring was in place to minimize the risk of altercations and potentially harmful interactions between the residents.

The severity of harm is actual harm.
The scope is isolated.
The compliance history is no previous non-compliance
(189)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** May 19, 2017

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 23rd day of February, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Veron Ash

**Service Area Office /**
**Bureau régional de services :** Toronto Service Area Office