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 prévue 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 14, 2019	2018_759502_0020	008351-17, 008573-17, 000399-18, 006110-18, 009937-18, 011104-18, 011585-18, 019940-18, 023051-18	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

JULIENNE NGONLOGA (502), ORALDEEN BROWN (698), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 13, 14, 15, 16, 19, 20, 21, 22, 26, 27, 28, 29, 30, December 3, 4, 5, and off-site on December 18, 2018.

A compliance order related to LTCHA 2007, c.8, s. 6 (11) (b) was identified during this inspection and has been issued in Inspection Report 2018_631210_0022, which was conducted concurrently with this inspection.

Five complaints (#008351-17, #008573-17, #006110-18, #019940-18, and #023051-18) were submitted to the Director related to multiple care concerns.
Three complaints (#000399-18, #011104-18, #011585-18), were submitted to the Director related to abuse.
One complaint (#009937-18), was submitted to the Director related to transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Office Manager, Physiotherapist (PT), Physiotherapist Assistant (PTA), Occupational Therapist (OT) Social Worker, Maintenance staff, Physiotherapist, Food Service Manager (FSM), Registered Dietitian (RD), residents and family members.

The inspector(s) observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigation notes, staff schedule and home's policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC) in 2017, related to fall prevention program. The complaint reported that resident #011 had frequent falls in the home and sustained injuries.

A review of resident #011's clinical record indicated the resident had six falls within three months after they were admitted to the home. The resident was transferred to the hospital after the last noted incident of fall.

A review of the written plan of care indicated that resident #011 was at high risk for falls related to a history of falls, and the home put in place specified strategies when the resident was ambulating or up in wheelchair.

A review of resident #011's post fall assessment huddle and progress notes indicated

that on an identified date in 2017, the resident tried to reach for a personal item that was on the floor and fell from the wheelchair in an identified area. On the same day, PT #113 documented the personal item to be changed to another personal item, to prevent the resident from leaning forward to pick up the first personal item each time they fall off. Registered Practical Nurse (RPN) #110 documented in progress notes that the resident would benefit from the second personal item instead of wearing the first personal item upon return from hospital.

Interviews with ADOCs #111 and #108 indicated that there was an audit performed two months prior to the incident of fall mentioned above, for the safety of the first personal item and that resident #011 was evaluated and recommendation made for them to wear the second personal item. ADOCs #111 and #108 were not able to explain why resident #011 was wearing the first personal item on the day of the fall incident mentioned above, when they were supposed to be wearing the second personal item as per the written plan of care. [s. 6. (7)]

2. A complaint was submitted to the MOHLTC in 2018, related to fall prevention in the home. The complainant alleged that resident #015 had multiple falls with injury and that the resident's plan of care was not being followed.

The Inspector reviewed resident #015's progress notes and the following fall incidents were documented:
- In May 2017, resident #015 had a fall with no injury.
- In December 2017 and May 2018, resident #015 had two incidents of fall with injury.

In November 2018, the inspector observed resident #015 in a specified care area, sitting in the wheelchair with the right brake on. The resident was not engaged in any self-directed activity. Staff were not present at the specified care area and the resident was not visible to staff. The chair alarm was turned off, the resident was trying to get up by holding onto an identified chair close by.

On the same day, PSW #136, arrived at the specified care area, turned the chair alarm on and told the inspector that the resident should not be left unsupervised at that care area. They took the resident for a walk around the unit. Few minutes later, the resident was observed in another care area without staff supervision.

The Inspector reviewed resident #015's current care plan in effect during the fall incident mentioned above, and it indicated that the resident was moderately impaired and they

were high risk for fall. Further review of the resident's plan of care indicated the interventions that have been implemented related to the fall prevention for the resident included:
- do not leave the resident in a specified care area,
- place the resident in another specified care area engaged in self-directed activities,
- wheelchair alarm applied when the resident is up in wheelchair.

PSW #101 told the inspector that the resident should stay at the specified care area with supervision. If no one is around, the resident should be placed in a second care area so that staff can monitor them from any angle.

In an interview, PSW #121 indicated that on the day of the second fall incident in May 2018, they placed resident #015 in a specified care area without supervision, and proceeded to provide care to other residents. PSW #121 stated that they were not aware resident #015 was not to be left unsupervised in that specified care area, it was their first day at work in the home. The resident was found on the floor by other staff.
In an interview, ADOC #108 acknowledged that care was not provided as outlined within the resident's plan of care as the PSW left the resident unsupervised in the care area mentioned above. [s. 6. (7)]

3. Multiple complaints were submitted to the MOHLTC in 2018. The complainant reported that resident #008 had recurrent identified medical condition due to staff negligence, evidenced by specified care was not provided.

Review of resident #008's written plan of care indicated that the resident was admitted in the home in April 2017. On admission the resident was continent with a specified treatment that was to be change monthly.

Review of the resident's electronic treatment administration record (e-TAR) revealed that the specified treatment was not changed for a period of 61 days.

During an interview with ADOC #111, they indicated that the resident's specified treatment was not changed for two months after admission, and acknowledged that the care was not provided as per the plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Multiple complaints were submitted to the MOHLTC in 2018. The complainant reported that resident #008 had recurrent identified medical condition due to staff negligence, evidenced by specified care was not provided.

Review of resident #008's written plan of care indicated that the resident was continent with a specified treatment that staff were directed to monitor and document the effectiveness once per shift.

Review of Follow up question report for a period of eight months in 2018, indicated that staff did not record the effectiveness of the specified treatment during 15 identified shifts.

In an interview, PSW #134 indicated that the staff were expected to provide specified care, and then document on Point of Care (POC) every shift. Both PSWs #134 and #135 indicated that the resident's substitute decision maker (SDM) raised concern with the management team related to the care the resident was receiving. As result, staff assignments were changed and they did not remember if the care was provided as per the plan of care.

In an interview, PSW #138 indicated that the resident voided a lot. They indicated that when the night shift did not provide the specified care at the end of their shift, the day shift will provide the care at the beginning and end of their shift, and document once at the end of their shift.

In an interview, ADOC #108 acknowledged that there was a gap in documentation and they indicated that the staff did not document. [s. 6. (9) 1.]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Multiple complaints were submitted to the MOHLTC in 2018. The complainant reported that resident #008 had recurrent identified medical condition due to staff negligence, evidenced by specified care was not provided.

Review of resident #008's written plan of care indicated they were admitted in the home in 2017. On admission the resident was continent with a specified treatment.

Review of resident #008's progress notes revealed that:

- The resident's continence status declined from continent to incontinent as the specified treatment was discontinued as per physician's order in 2017.
- In December 2017, resident #008's continence status improved from incontinent to continent as the specified treatment was initiated again due to specified condition.

Record review of the continence assessment tool on point click care (PCC) did not identify a completed continence assessment when resident #008's continence level changed in August 2017, and December 2017.

In an interview, ADOC #111 acknowledged that a continence assessment was not completed for resident #008 after a change in their continence status. The ADOC indicated that the unit nurse were responsible for assessing the resident when the level of continence changed. [s. 6. (10) (b)]

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 care set out in the plan of care is provided to the resident as specified in the plan, that the provision of the care set out in the plan of care was documented, and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A complaint was submitted to the MOHLTC in May 2018, related to fall prevention in the home. The complainant reported that resident #015 had multiple falls with injury.

The review of resident #015's progress notes revealed that in January 2018, at an identified time, PSW #101 was wheeling the resident out of an identified care area after specified care. The resident's wheelchair tilted all the way backwards, the resident fell out of the wheelchair and hit an identified body part, resulting in a lot of pain and injury.

Upon assessment of the wheelchair, a registered nurse noted that the small bars at the back of wheelchair (anti-tipper), which were used to prevent the wheelchair from flipping backwards was not properly fixed in place. One of the anti-tipper bars was freely flipping from side to side, and then stuck in the wheel of the wheelchair, causing the resident's wheelchair to flip backwards. The other anti-tipper was missing.

Review of resident #015's quarterly minimum data set (MDS) assessment indicated that the resident had cognitive impairment. Review of the resident's written care plan indicated that the resident had limited physical mobility related to an identified medical condition, and required assistance of one staff to ambulate with the wheelchair.

In an interview, PSW #101 told the inspector that on the day of the fall incident mentioned above, they were pushing resident #015 out of an identified care area after care, when the wheelchair suddenly flipped backward. PSW #101 indicated that the wheelchair was missing something on the back of the wheelchair, and that the other bar was loose and turned upside down. When they were pushing the chair, the anti-tipper bar got stuck in the wheel and the resident flipped backwards. The PSW stated that they did not check the chair prior to transferring the resident for specified care.

In an interview, ADOC #108 confirmed the fall incident mentioned above. ADOC #108 acknowledged that the resident's wheelchair was not safe to use on the day of this fall incident due to a missing anti-tipper bar. The ADOC indicated that the PSW was disciplined for neglect as they had not checked that the anti-tipper function was working on the wheelchair before transferring the resident. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following actions taken in response to the incident:
i. what care was given or action taken as a result of the incident and by whom,
ii. whether a physician or Registered Nurse in the Extended Class was contacted,
iii. what other authorities were contacted about the incident, if any
iv. whether a family member, person of importance or SDM of any resident(s) involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.

A critical incident system (CIS) report was submitted to the Director in May 2018, related to staff to resident abuse. Resident #008's family member alleged that an incident of abuse occurred, and the alleged incident was reported to the nurse manager in the home. The home initiated an internal investigation and submitted the CIS report the same day to the Director.

In an interview, ADOC #108 indicated that the home's investigation was completed and that the allegations were not founded.

The inspector reviewed the CIS and did not identify an amended CIS report related to alleged incident of abuse mentioned above.

The ADOC acknowledged that the CIS report was not amended to include the outcome or current status of the individual or individuals who were involved in the alleged incident of verbal and physical abuse mentioned above. [s. 104. (1) 3.]

2. The licensee has failed to ensure that the report to the Director included the following analysis and follow-up actions:
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence

A CIS report was submitted to the Director in May 2018, related to staff to resident abuse. Resident #008's family member alleged that an incident of verbal and physical abuse occurred.

The inspector reviewed the CIS report and noted that the alleged incident was reported

to the nurse manager in the home. The home initiated an internal investigation and submitted the CIS report the same day to the Director. The inspector also noted the long-term actions were not included on the CIS report as the home documented that the long-term actions will be planned based on outcome of investigation.

Review of the home's investigation notes indicated that the investigation was completed and the following long-term actions planned to correct the situation and prevent recurrence were implemented:
- a registered staff to be present when the PSW provided care to the resident,
- rehabilitation staff #122 was removed from the floor, and
- PSW #123 was removed from caring for resident #008.

The CIS report was not amended to reflect those long-term actions.

During an interview, ADOC #108 confirmed that the long-term actions mentioned above were implemented, and they acknowledged that these long-term actions were not included in the CIS report. [s. 104. (1) 4.]

Issued on this 22nd day of January, 2019

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

Original report signed by the inspector.