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
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5700 rue Yonge 5e étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 22, 2019	2018_631210_0022	008182-17, 024746-18, 024748-18, 024750-18, 025828-18, 029034-18	Critical Incident System

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

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

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 7, 8, 9, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, December 3, 4 and 5, 2018.

A compliance order related to LTCHA 2007, c.8, s. 6 (11)(b) identified in a concurrent inspection #2018_759502_0020, (log #009937-18), was issued in this report.

During the course of the inspection, the following Critical Incident intakes was inspected:

-Intake log #008182-17, (CIS #2945-000016-17), related to alleged staff to resident abuse;

During the course of the inspection the following follow up intakes were inspected:

- Intake log #024746-18, #024748-18 and #024750-18 related to personal support services;
- Intake log #025828-18 related to skin and wound care management;
- Intake log #029034-18 related to dining and snack service.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSW) and Physiotherapist (PT).

The inspectors performed observations of staff and resident interactions, provisions of care, reviewed residents clinical records, staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **1 WN(s)**
- **0 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #003	2018_712665_0003	210
O.Reg 79/10 s. 50. (2)	CO #001	2018_420643_0012	210
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_712665_0003	210
O.Reg 79/10 s. 73. (1)	CO #001	2018_631210_0011	210

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident was reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care.

A complaint was submitted to the Ministry of health and Long Term Care (MOHLTC) on a specified date, by a family member of resident #011 indicating that the resident sustained injuries because of altered locomotion.

A review of resident #011's clinical record indicated the resident was admitted to the home on a specified date, and had five altered mobility (being able to walk without asisstive device) incidents in their room or the common area. Further review of resident #011's incident history indicated the resident had three altered locomotion (not being able to walk without assisstive device) incidents (unwitnessed) from their locomotion device and during two incidents they were transferred to hospital for further assessments.

A review of the written plan of care indicated resident #011 was at high risk for altered locomotion. The strategies to prevent altered locomotion that were initiated on particular dates in the plan of care were:
-Non-slid assisting item, bed and chair/locomotion device alarm, floor mattress, hi-low bed, bed in lowest position, positioning pillows, half lap-tray on locomotion device, hip protectors.

A review of the home's monthly incidents management meeting notes and interview with ADOC #111 indicated during the monthly meetings the strategies that were in place and added for residents with altered locomotion were discussed with registered staff on the units. The ADOC #111 would take notes of the current safety management strategies and give a copy to the registered staff in order to update the care plan.

A review of monthly incidents management meeting notes from several specified dates, indicated that the following interventions for resident #011's altered locomotion were discussed: floor mat, posey alarm, hi-low bed and helmet.

Interview with ADOC #111 and review of the post incident assessment huddles on two specified dates indicated that immediate actions that were taken to prevent reoccurrence of the altered locomotion were not documented. Lack of documentation impacted the

ability to evaluate if the present interventions in the written plan of care were effective and if new interventions should be introduced.

A review of the Physiotherapist's (PT) assessment during admission indicated that resident #011 was at risk for altered locomotion related to new environment, history of altered mobility and posture. The PT recommended that the resident would benefit from enhanced monitoring and application of a posey alarm (applied to the mobility device) to reduce the risk for altered locomotion and injury. The inspector was not able to interview the PT because they do not work in the home anymore.

Interview with ADOC #111 indicated that the incident prevention strategies and evaluation discussed at the monthly meetings mentioned above should be documented in the resident's care plan so that the PSWs can access and implement them.

A review of the post incident assessment huddles and interview with ADOC #111 indicated the interventions were not evaluated for efficacy during a specified three months period, and they were not documented in the resident's care plans. ADOC #111 was not able to confirm that the prevention strategies and evaluations discussed at the monthly meetings mentioned above were consistently implemented by staff on all shifts.

According to RPN #110, they updated the interventions for prevention of altered locomotion in resident #011's written care plan on a specified date, and they were not able to confirm that these interventions were in place prior to the interventions update and after the resident had five altered locomotion incidents. [s. 6. (11) (b)]

2. A complaint was submitted to the MOHLTC on a specified date, related to altered locomotion incidents of a resident in the home. The complainant reported that resident #015 had multiple altered locomotion incidents with injury.

The Inspector reviewed resident #015's progress notes and the following altered locomotion incidents were documented:
A) Review of the first incident
On a specified date, the alarm on resident #015's locomotion device was activated when the resident tried to move. The resident had an altered locomotion incident and didn't sustain injury.

The Inspector reviewed resident #015's care plan after the date of the the above mentioned incident. The resident's care plan was revised to include:

-Place the resident at the nursing station and engage them with self-directed activities, floor mattress, bed and locomotion device alarm.

In an interview, PSW #127 indicated that all unit staff were in a particular area of the unit where resident #015 was. The PSW stated that they were in the same area, when they heard a noise and noticed that the resident had an altered locomotion incident. They were not sure if the device alarm was in place.

B) On another specified date, resident #0015 was assisted with an activity of daily living (ADL) using the locomotion device. Three staff were doing activities in the particular area of the unit when they heard the resident's device alarm activated. The resident had an incident with altered locomotion before the staff was able to attend to them. The resident was transferred to hospital for further assessment because of an injury. According to the progress notes the resident self-transferred from the locomotion device at the time of the incident.

The Inspector reviewed resident #015's Post incident huddle on a specified date, and noted an incident analysis was completed and the plan of care was revised.
The inspector reviewed the resident's care plan in effect after the incident on a specified date, and noted the following interventions:
- Apply wedge pillow when in bed, floor mattresses, high-low bed, monitor closely, place the resident in the nursing station under supervision, locomotion device to be locked when not in motion, locomotion device alarm, helmet and hip protector.

Interviews with staff indicated four staff were present in a particular area of the unit during the incident on a specified date. PSW #137 indicated that they were assisting another resident located close to resident #015 but with their back turned to the resident. PSW #127 was heading towards another resident's room. PSW #130 was at a corner of the particular area not able to monitor the resident. RPN was in the proximity of the particular area administrating medications. Although all four staff were close to the resident, they did not know what had happened; they heard the alarm and by the time they were able to attend, the resident had already sustained altered locomotion. The locomotion device was behind the resident. The alarm was on but staff did not know if the brakes were on.

In an interview, ADOC #108 indicated that the analysis of each incident was included in the post incident huddle form. From the resident's incident analysis the home found that when the resident had a visitor and they were leaving, they seemed to be at higher risk

for incidents when the visitor leaves. The staff also identified that the resident was able to release the device brake, and the clip alarm was replaced with a pad alarm.

ADOC #108 indicated that the resident's substitute decision maker (SDM) inquired about the use of an alternative intervention to prevent re-occurrence of incidents of altered locomotion, but the home believed that it would not be safe and after discussion with SDM they did not apply it.

The inspector reviewed the post incident huddle form and noted that the care plan was revised. However, the resident's written plan of care did not identify alternative approaches to address the risk associated with the re-occurrence of altered locomotion incidents in the particular area of the unit where resident #015 had most of the incidents. [s. 6. (11) (b)]

Additional Required Actions:

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

Issued on this 8th day of February, 2019

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

Ministère 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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SLAVICA VUCKO (210), JULIENNE NGONLOGA (502), ORALDEEN BROWN (698)
Inspection No. / No de l'inspection :	2018_631210_0022
Log No. / No de registre :	008182-17, 024746-18, 024748-18, 024750-18, 025828-18, 029034-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 22, 2019
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Woodbridge Vista Care Community 5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lora Monaco

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

Ministère 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

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:

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

Ministère 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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_712665_0003, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,

(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee must be compliant with s. 6 (11) (b) of the LTCHA.

Specifically, the licensee must prepare, submit and implement a plan to ensure that when residents #011 and #015 are reassessed and the plan of care reviewed and revised because the care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care.

The plan must include, but is not limited to the following:
1) Identify different approaches to reduce the risk of altered locomotion incidents for residents #011 and #015 and any other resident identified as having recurrent incidents and update the plan of care.
2) Develop and implement an audit tool to monitor (daily for one month, then weekly untill the compliance date) and ensure that the plan of care for residents #011 and #015 and all other identified residents having recurrent incidents is updated with different approaches if the plan has not been effective.

The home is required to maintain a documented record of the audit, the date the audits are conducted, who completed the audits, and the outcome of the audits.

Please submit the written plan for achieving compliance for 2018_631210_0022 to Slavica Vucko, LTC Homes Inspector, MOHLTC, by email to TorontoSAO.moh@ontario.ca by February 22, 2019.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that when the resident was reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care.

A complaint was submitted to the Ministry of health and Long Term Care (MOHLTC) on a specified date, by a family member of resident #011 indicating that the resident sustained injuries because of altered locomotion.

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The inspector reviewed the post incident huddle form and noted that the care plan was revised. However, the resident's written plan of care did not identify alternative approaches to address the risk associated with the re-occurrence of altered locomotion incidents in the particular area of the unit where resident #015 had most of the incidents.

The severity of this issue was determined to be level 3 as there was actual harm to resident #015. The scope of the issue was level 2 as it related to two of three residents reviewed. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
-voluntary plan of correction (VPC) issued February 12, 2018 (2017_527665_0012);
-compliance order (CO) #002 issued July 16, 2018 with a compliance due date of October 10, 2018 (2018_712665_0003). (210)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 29, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Slavica Vucko

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