Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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 19, 2021	2020_780699_0020	002970-20, 005195-20, 005467-20, 012737-20, 020422-20, 021458-20	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

PRAVEENA SITTAMPALAM (699), IVY LAM (646)

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 23-26, 30 and Dec 1-4, 7-8, 2020.

The following intakes were inspected during this inspection:

-Log #021458-20 [Critical Incident System (CIS) 2945-000050-20] related to an unexpected death;
-log #020422-20, 002970-20, 012737-20, 005467-20 and 005195-20 [CIS 2945-000046-20, 2945-000007-20, 2945-000020-20, 2945-000013-20, and 2945-000012-20] related to falls.

During the course of the inspection, the inspector(s) spoke with Consultant Director of Care (CDOC), Director of Care (DOC), Associate Executive Director (AED), Associate Director of Care (ADOC), registered practical nurse (RPN), and personal support worker (PSW).

During the course of the inspection, the inspectors conducted observations of staff and resident interactions and provision of care, reviewed resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007's fall interventions were provided to the resident as specified in the plan.

The Ministry of Long-term Care (MLTC) received a Critical Incident System (CIS) report related to a fall resident #007 sustained which resulted in an injury. The inspector observed resident #007 in their room on December 4, 2020 and did not observe a specific fall intervention in place. PSW #128 was assigned to the resident on December 4, 2020, and confirmed they were unaware the resident required the specific fall intervention to be in place, and that the interventions were not in place. The expectation of staff is to ensure that interventions are in place as per plan of care and to report to registered staff if interventions are not in place.

This non compliance is additional evidence for a compliance order issued in inspection report #2020_769646_0019, that was inspected concurrently with this inspection.

Sources: Care plan, observations conducted December 4, 2020, interviews with PSW #128, RPN #123, RPN #105, AED #119 and DOC #102.

Issued on this 19th day of January, 2021

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

Original report signed by the inspector.