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

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
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 01, 2021	2020_769646_0019 (A1)	010131-20, 014908-20	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

Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Amendment to language in compliance order #001, step #3.

Issued on this 1 st day of February, 2021 (A1)

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

Original report signed by the inspector.

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

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

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

Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Amended 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): December 2, 3, 4, 7, and 8, 2020.

The following intakes were completed during this inspection:

Complaint Log # 010131-20 related to skin and wound and falls prevention, and

Log #014908-20 related to resident’s care not provided as per care plan.

For s. 6(7): Additional evidence supporting this non-compliance was identified in the following inspection report: 2020_780699_0020, that was inspected concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Corporate Consultant, the Director of Care (DOC), Assistant Director of Care (ADOC), skin and wound lead, falls lead, Registered Nurses (RN)s, Registered Practical Nurses (RPNs), the Physiotherpist (PT), Behaviour Supports Ontario (BSO) - RPN, previous agency RPN, Personal Support Workers (PSWs), office manager.

During the course of the inspection, the inspector conducted tours of the home, observations of the home and resident home areas, resident and staff interactions, reviewed clinical health records, treatment and medication administration records, staffing schedule and staffing plans, internal investigation notes, and relevant home policies and procedures

The following Inspection Protocols were used during this inspection:

Falls Prevention
Skin and Wound Care

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

2 WN(s)
1 VPC(s)
1 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 the staff and others involved in the different aspects of care of resident #008 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

The resident was found with an injury one day. Twelve days later, the resident was found with another injury on a different part of their body.

The home's skin and wound care protocol stated that when a resident exhibits altered skin integrity, the nurse will collaborate with resident, Substitute Decision Maker (SDM) and interprofessional team to develop and update the plan of care.

Review of resident's care plan did not show any interventions to address the resident's behaviours or to prevent injury.

The Director of Care (DOC) stated that the staff should have collaborated to determine the cause of the resident's injuries and provided additional monitoring. The Behavioural Support staff should have been consulted to review if behaviours could have contributed to the bruising. The interprofessional team should have collaborated in the assessment of the resident.

Sources: Resident #008's Head to Toe Assessments - V 2.0, care plan, Post Fall Incident Forms, progress notes, Risk Management Notes, home's Skin & Wound Care Management Protocol (Policy #VII-G-10.90), interviews with the DOC and

other staff members. [s. 6. (4) (a)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of resident #008 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The resident was moved to another unit. No documentation was done on the day prior or the day of the transfer related to the resident's unit transfer.

The resident was at risk for falls, but the staff on the original unit did not collaborate with the staff on the new unit to develop and implement the resident's plan of care for falls prevention. The resident required close monitoring in a common area, which could no longer be provided to the resident due to the home's outbreak protocol. A plan was not developed or implemented to provide the resident with close monitoring when they were isolated in their room on the new unit.

Staff reported that there had not been direction from the management regarding how to closely monitor residents in their rooms, and they had not raised the question to the DOC or other nurse managers.

The DOC stated there was a lack of collaboration in developing and implementing the resident's plan of care for falls when the resident was to be closely monitored in a common area, but this was not possible due to COVID-19 precautions.

The resident was found with injury from a fall ten days after they were transferred to the new unit.

Sources: Resident #008's care plan, Post Fall Incident Forms, progress notes, Risk Management Notes, Documentation Survey Report v2, home's electronic communication and investigation notes, interviews with PSWs, RPNs; the ED, the DOC, and other staff. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan.

The resident was at risk for falls, and was to be provided with close monitoring and two specific falls prevention interventions. Furthermore, the resident was not

to be left alone in an identified area.

A. The resident had an unwitnessed fall in the identified area where they were not supposed to be left alone.

At the time of their fall, the resident was not closely monitored as per their care plan and was left unattended in an identified area where they had an unwitnessed fall.

Review of the post fall incident form and the progress notes did not indicate whether the resident had the two specific falls prevention interventions at the time of this fall, and the staff could not accurately recall if the resident had these with them at the time.

B. The resident had an unwitnessed fall several months later and was found by an RPN in their room. The post fall incident form and the progress notes did not indicate whether the resident had the two specific falls prevention interventions at the time of this fall.

The ED investigated the fall incident and found that the two specific falls prevention interventions were not provided to the resident at the time of the fall.

A PSW stated there was no communication regarding how to closely monitor the resident in the common area, and staff were not monitoring the resident at the time of the fall.

Interview with the DOC stated close monitoring and one of the falls prevention interventions were not in place for the resident at the time of their second fall, but was uncertain if the other intervention was provided for the resident at the time of the second fall.

The resident was not closely monitored and the intervention was not provided at the time of their second fall. The resident was found with injuries from the fall.

Sources: Resident #008's care plan, Post Fall Incident Forms, progress notes, Risk Management Notes, PT assessment, Nurse Practitioner assessment, home's electronic communication and investigation, interviews with the ED, DOC, RPN, PSWs, and other staff members. [s. 6. (7)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #008 who exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

The following is further evidence to support the compliance order issued during inspection 2020_780699_0013.

Resident #008 had a fall. Review of the resident’s head to toe assessment and nurse practitioner assessment from the fall showed they had identified injuries. The resident was transferred to the hospital for further assessment and returned to the home the same day.

Review of the resident’s clinical assessments did not show any weekly skin assessment related to the resident’s injuries done after the fall. Review of the resident’s electronic medication administration record (eMAR) during the month of the resident's fall and the month following, did not show any assessment or treatment ordered or provided for the resident related to their injuries from the fall.

The ADOC #103, who was the current skin and wound lead, and the DOC stated that a weekly skin assessment should have been done for the resident after the initial assessment on the day of the fall until the time the injury was healed, and that this was not done for the resident.

Sources: Resident #008’s head to toe assessment, PCC clinical assessments, progress notes, Nurse Practitioner assessment, eMARs, and electronic treatment administration record (eTAR), interviews with the ADOC, DOC, and other staff members. [s. 50. (2) (b) (iv)]

Issued on this 1 st day of February, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care	Ministère des Soins de longue durée
Order(s) of the Inspector	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8	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 Operations Division
Long-Term Care Inspections Branch

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by PRAVEENA SITTAMPALAM (699) - (A1)
Inspection No. / No de l'inspection :	2020_769646_0019 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	010131-20, 014908-20 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 01, 2021(A1)
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 :	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 # / No d'ordre: 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

(A1)
The licensee must comply with LTCHA, 2007 S.O. 2007, c.8, s. 6 (7).

Specifically, the licensee must:

1) Develop and communicate strategies to all registered staff and PSWs on how to monitor residents during isolation and/or when residents are not able to be monitored in common areas.

2) Keep a sign-in sheet including the names of staff and dates when the communication was given, to show that the staff have received and reviewed the monitoring strategy.

3)Ensure that any residents living in the home who have been transferred within the home between 2020 to receipt of this order, and any resident thereafter, have their plan of care communicated to direct care staff.

4) Ensure that residents who are identified as at risk for falls have their falls prevention interventions provided as per their plan of care.

5) Conduct follow-up audits for item #3 and #4 for a period of one-month following the service of this order. Ensure the audit record is kept, including the date of the audit, the names of the residents, any issues identified, and action taken.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan.

The resident was at risk for falls, and was to be provided with close monitoring and two specific falls prevention interventions. Furthermore, the resident was not to be left alone in an identified area.

A. The resident had an unwitnessed fall in the identified area where they were not supposed to be left alone.

At the time of their fall, the resident was not closely monitored as per their care plan and was left unattended in an identified area where they had an unwitnessed fall.

Review of the post fall incident form and the progress notes did not indicate whether the resident had the two specific falls prevention interventions at the time of this fall, and the staff could not accurately recall if the resident had these with them at the time.

B. The resident had an unwitnessed fall several months later and was found by an RPN in their room. The post fall incident form and the progress notes did not indicate whether the resident had the two specific falls prevention interventions at the time of this fall.

The ED investigated the fall incident and found that the two specific falls prevention interventions were not provided to the resident at the time of the fall.

A PSW stated there was no communication regarding how to closely monitor the resident in the common area, and staff were not monitoring the resident at the time of the fall.

Interview with the DOC stated close monitoring and one of the falls prevention interventions were not in place for the resident at the time of their second fall, but was uncertain if the other intervention was provided for the resident at the time of the second fall.

The resident was not closely monitored and the intervention was not provided at the

time of their second fall. The resident was found with injuries from the fall.

Sources: Resident #008's care plan, Post Fall Incident Forms, progress notes, Risk Management Notes, PT assessment, Nurse Practitioner assessment, home's electronic communication and investigation, interviews with the ED, DOC, RPN, PSWs, and other staff members.

An order was made by taking the following factors into account:

Severity: There was actual of harm to resident #008 because the care set out in the plan of care was not provided to the resident.
Scope: Out of the three residents reviewed, two residents were affected.
Compliance History: In the past 36 months, the licensee was found to be non-compliant with LTCHA s. 6.(7), and three voluntary plans of correction (VPC) and one compliance order (CO) were issued. (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 09, 2021

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 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 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 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 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 1 st day of February, 2021 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by PRAVEENA SITTAMPALAM (699) - (A1)

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