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
Mar 8, 2021	2021_808535_0002	002971-20, 021493-20, 022863-20, 025136-20	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

VERON ASH (535), NAZILA AFGHANI (764)

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): January 25, 26, 28, 29, February 1, 2, 3, 4, 5, 8, 9, 10, 11, offsite January 27, February 12, 16, 17, 2021.

The following intakes were completed during this inspection:

Log #002971-20 was related to abuse,
Log #021493-20 was related to neglect,
Log #022863-20 was related to abuse, and
Log #025136-20 was related to neglect.

During the course of the inspection, the inspector(s) spoke with the inspector(s) spoke with the Interim Executive Director (ED), Interim Director of Care (DOC), Associate Director of Care (ADOC), Responsive Behavior Lead, Physiotherapist, Resident Assessment Instrument Coordinator (RAI-C), registered staff (RN/RPN), personal support workers (PSWs) and substitute decision-makers (SDM).

During the course of the inspection, the inspectors conducted observations on the resident home areas and staff to resident interactions, reviewed clinical health records, staffing schedule, internal investigation records and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that to ensure that the neglect of a resident by a staff was immediately investigated.

A critical incident system (CIS) report was received by the Ministry of Long-Term Care (MLTC) regarding neglect of a resident.

The SDM informed the staff that the resident was admitted to the hospital with a specific diagnosis; and that they felt there was a case of neglect and they would be reporting to the MLTC.

The CIS indicated that an investigation was in progress. Therefore, the inspector requested the home's investigation notes for review, and the Interim DOC (IDOC) stated that the previous DOC was no longer working in the home, and they were unaware of the result of an investigation. There were no investigation notes available related to this incident.

Sources: CIS report and interview with the IDOC and others. [s. 23. (1) (a)]

2. The licensee has failed to ensure that the alleged abuse of a resident by a staff was immediately investigated.

A CIS report was received by the MLTC regarding the physical abuse of a resident.

The home submitted a critical incident report to the MLTC in response to the resident's SDM alleged complaint that the resident was injured by a PSW about a week ago. The CIS indicated that an internal investigation would be started. The inspector requested the home's investigation notes for review, and the Interim DOC (IDOC) stated that the previous DOC was no longer working in the home, and they were unaware of the result of an investigation. There were no investigation notes available related to this incident.

Sources: CIS report and interview with the IDOC and others. [s. 23. (1) (a)]

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 neglect of a residents by staff was immediately investigated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident's skin and wound care, including assessment of a bruise to the resident’s left lower forearm, was documented.

The MLTC received a CIS report regarding abuse of a resident.

The RN called the resident's SDM to translate in their native language because the resident was refusing personal care. The SDM informed the staff that the resident was refusing care because they experienced an injury while care was being provided by a PSW in the past.

The RN reported the incident of possible abuse to the home’s previous DOC, who initiated an internal investigation and contacted both SDMs for more information.

A RPN completed the resident’s head to toe assessment and documented an area of altered skin integrity to a identified part of the resident's body. The RPN reported their finding to the SDM and previous DOC.

The PSW stated that they may have seen the area of altered skin integrity, however they may have forgotten to document it in the point of care (POC).

The Resident Assessment Instrument Coordinator (RAI-C) verified that during that week, PSWs did not document related to altered skin integrity for the resident in point of care (POC).

Sources: Resident's progress notes and head to toes assessment records, interview with RPN, PSW and others. [s. 30. (2)]

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 any actions taken with respect to a program, including assessment and reassessment were documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee has failed to ensure strategies were developed and implemented to meet the needs of a resident and those residents who cannot communicate in the language used in the home.

The RN called the resident's SDM to translate in their native language because the resident was refusing personal care. They acknowledged that the resident understood a few words of English, and that the resident spoke their native language which was different. The staff verified that they usually access staff who speaks the native language when available in the home, or call residents' SDMs since the home does not provide other communication tools/strategies to support the language barrier between the staff and residents. The RN also stated that majority of the residents residing in the home speak their native language; and it would be helpful to have access to other tools/strategies to support translation and communicating with residents.

As a result of this non-compliance, the sample was expanded to include two other residents which provided additional non-compliance since both residents communicated in their native language which was not English.

Sources: Residents' plan of care and progress notes; interview with RN and others. [s. 43.]

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 strategies are developed and implemented to meet the needs of those resident who cannot communicate in the language used in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident was free from neglect by the licensee or staff in the home.

Section 2 (1) of the Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

The MLTC received a CIS report regarding neglect of a resident. The following is further evidence to support a previous compliance order issued to the home under this same subsection of the Long-Term Care Homes Act, 2007 (LTCHA).

The home submitted a CIS report to the MLTC in response to a resident's substitute decision-maker (SDM) telephone complaint to the registered staff concerning the resident's admission to hospital and a specific diagnosis. The SDM raised a concern of neglect and told the staff that they would be reporting the neglect to the MLTC.

The resident's progress notes and an interview with the RPN revealed that the resident refused to participate in activities and specific treatment for over a week, stating that they felt unwell. Prior to their transfer to hospital, the resident refused all meals, displayed symptoms and had an elevated vital sign.

The Nurse Practitioner (NP) attended the unit, assessed the resident, noted the elevated vital sign; however because they had a history of that same condition, the SDM decided to keep the resident in the home.

During the next shift, a second RPN called the SDM and reported the elevated vital sign, and also reported the resident's refusal to participate in activities and accept treatment for over a week and other signs of concerns. Soon after the call, the SDM attended the home and requested that the resident be transferred to hospital.

A review of the resident's clinical records indicated that they were prone to the specific diagnosis since they were treated multiple times over a period of months. During the last diagnosed incident, the resident did not receive the full treatment of medication prescribed by the physician. However, the physician was not notified by the registered staff.

The first RPN acknowledged that they did not discuss the resident’s other signs and symptoms with the NP when they came to the unit to assess the resident. They acknowledged that when all of the resident’s signs and symptoms were reviewed together, in retrospect they realized that the resident was unwell and required medical attention. The staff stated that they were focused on the resident’s elevated vital sign, but that they should have reported all the issues/concerns to ensure appropriate treatment.

Sources: CIS report, resident's progress notes, EMAR, laboratory records, and interview with both RPNs, DOC and others. [s. 19. (1)]

Issued on this 10th day of March, 2021

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

Original report signed by the inspector.