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
May 18, 2022	2022_772691_0009	004724-21, 013187-21, 013240-21, 013260-21, 013296-21, 016409-21, 018362-21, 019424-21, 020998-21, 000921-22	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

JENNIFER NICHOLLS (691), AMY GEAUVREAU (642), SYLVIE BYRNES (627)

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): March 21-25, and 28-29, 2022. Offsite inspection activities occurred on March 30-31, 2022.

The following intakes were inspected upon during this Complaint inspection:
-Two Logs related to Infection Prevention and Control (IPAC);

-Eight Logs related to allegations of abuse, neglect and improper care of a resident.

During the course of the inspection, the inspector(s) spoke with residents and family members, the acting Administrator, Director of Care (DOC), Assistant Director of Cares (ADOCs), Infection Prevention and Control (IPAC) lead, Environmental Services Manager, Physiotherapist, Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, Scheduler, and Screeners.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of resident care and services, observed staff and resident interactions, observed infection control practices, reviewed relevant health care and media records, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Safe and Secure Home

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

8 WN(s)
4 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there was a written plan of care for the residents that set out the planned care for the resident.

a) A resident's family members stated that they were advised that the resident would be provided with a specific intervention.The resident's care plan did not identify that the resident was to receive this specific intervention.

The Director of Care (DOC) stated the home provided this specific intervention when possible, and that the resident's care plan should have been updated to identify that the resident was to receive this specific intervention when available.

b) The licensee has failed to ensure that there was a written plan of care for a resident that sets out clear directions to staff, related to a specific fall prevention intervention.

A resident's family members stated that they were advised that the resident would be provided with a specific fall prevention intervention. One of the resident's care plan provided direction to staff to provide the specific fall prevention intervention at specified times; while the revised care plan provided different direction to staff to in relation to this fall prevention intervention.

The DOC stated that they provided this specific fall prevention intervention when

possible, and that the resident's care plan should have been updated as it did not provide clear direction to staff related to resident monitoring.

Sources: Interviews with resident's family members; DOC and other staff members; resident's Point of Care (POC) documentation and care plans; home's schedule for specified time period; home's policy titled, "Documentation- Plan of Care [and] Care Plan Definitions", [s. 6. (1) (a)]

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

a) A resident had a fall when a specific intervention identified in their care plan was not in place.

Staff members, and the Director of Care (DOC) confirmed that the resident required this specified intervention as a safety strategy and this was not in place at the time of the fall.

The home's failure to provide the resident with the care as specified in the resident's plan presented potential for risk of harm.

Sources: Critical Incident System (CIS) report; review of the resident's health records, the homes' policy titled "Falls Prevention [and] Management, and interviews with the DOC, and other staff members.

b) A Personal Support Worker (PSW) found a resident after a fall in their room.

The home's internal notes indicated that the resident was not checked on as specified in their plan of care.

The resident's plan of care identified a specific safety plan.

The DOC verified that the resident's safety plan was not provided as specified in their plan of care.

The home's failure to ensure that the resident had been provide safety plan in a timely manner presented with actual risk of harm to the resident.

Sources: the home's policy titled "Resident safety Rounds"; resident's health care

records including care plan; internal investigation documents; interviews with the DOC; and other staff. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out the planned care for the resident and gives clear directions to staff and others who provide direct care to the residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure a PSW complied with the licensee's skin and wound care management policy.

Section 30 (1) 1 of the Ontario Regulations (O.Reg) 79/10 requires the licensee to have a written description of the program that included its goals and, objectives and, relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes.

Specifically, a PSW did not comply with the licensee's policy titled, "Skin [and] Wound Care Management Protocol" which directed PSWs to document electronically to record

any abnormal or unusual skin conditions; red or open areas, blisters, bruises, tears, rashes, scratches, and report to nurse.

A PSW identified that a resident had an area of altered skin integrity; however, the altered skin integrity was not reported until five hours later.

The lack of documenting and reporting of skin integrity issues to registered staff caused actual risk of harm to the resident.

Sources: interviews with PSW's; record review, home’s investigation notes, Home's policy titled, "Skin and Wound Management Protocol", [s. 8. (1) (b)]

2. The licensee has failed to ensure that the home’s policy for prevention and management of falls was complied with when a resident experienced a fall.

O. Reg.79/10, section 48 (1) 1. requires the home to have written policies and procedures for the falls prevention and management program. Specifically, registered staff did not comply with home’s policy titled, “Falls prevention and management”, which directed registered staff to use the appropriate lifting procedure post fall using a mechanical lift with two staff.

A resident was transferred by two staff members after falling. The PSWs did not follow the home's policy for safe transfers which required a mechanical lift.

The DOC indicated that the staff members should have completed the transfer as specified in the policy.

The staff's failure to follow the homes policy presented minimal risk to the resident.

Sources: the home's policy titled "Falls Prevention and Management"; "Zero lift and protocol"; CIS report; resident's health records; the home’s internal investigation notes; employee files including disciplinary forms; interviews with the DOC, and other staff.

3. The licensee has failed to ensure the RPN complied with the licensee’s falls prevention policy in regards to post falls assessment on a resident.

O.Reg 79/10, section 48 (1) 1. requires the home to have written policies and

procedures for the falls prevention and management program.

Specifically, registered staff did not comply with the home's policy titled "Falls prevention and management", which directed the nurse to assess resident post fall and to continue to monitor as per the schedule and monitor for any changes.

An RPN completed a post fall assessment for a resident who had fallen and injured themselves; however, the RPN failed to assess the resident's changing signs and symptoms in a timely manner.

The staff's failure of not appropriately assessing the resident’s clinical status caused potential risk of harm to the resident.

Sources: A resident's health records; the home’s investigation notes including employee file and disciplinary forms; the Home's policy titled, "Falls Prevention and Management”; CIS report; interview with the DOC, and other staff. [s. 8. (1) (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 policies are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning technique when assisting a resident.

A resident sustained a fall when they were transferred by two PSWs.The DOC stated that the PSWs had not followed the lift and transfer training they had been provided, which may have prevented the fall.

The lack of following safe transfer techniques, which lead to the resident's fall, caused actual harm to the resident.

Sources: interviews with PSW's, DOC and complainant; record review, home's investigation notes for CIS report; home's policy titled, "Zero Lift [and] Protocol". [s. 36.]

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 safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature of the water serving all bathtubs, showers, hand basins used by residents did not exceed 49 degrees Celsius.

A resident sustained a burn of unknown origin.Water temperatures taken from five different rooms in the home were above 49 degrees C.The EMS stated that the water was to be between 40 and 49 degrees and that their thermometers may not be accurate.

Water temperature above 49 degrees Celsius caused an actual risk of burn to residents.

Sources: Interviews with EMS, Environmental service worker; observations of water temperature checks in various rooms; record review; temperature logs for November 2021, for specified unit; current temperature long in units, : home's policy titled, "Water Temperature Monitoring". [s. 90. (2) (g)]

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 temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaint that had been received concerning the care of a resident or the operation of the home was forwarded to the Director.

A written complaint was submitted to the home by a resident's SDM; however the complaint was not submitted to the Director.

The Administrator verified that the written complaint concerning the care of the resident which also contained allegations of improper care should have been forwarded to the Director.

The home's failure to forward all written complaints to the Director presented minimal risk of harm to the resident.

Sources: The home's complaint investigation notes and complaint logs, the home's policy titled “Resident/Family Complaints Procedure", interview with the Administrator, and other staff. [s. 22. (1)]

WN #6: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of an investigation into an allegation of abuse of a resident was reported to the Director.

A complaint was submitted to the home regarding allegations of abuse and neglect. Although the home completed an investigation, the investigation undertaken was not reported to the Director.

The DOC identified they had investigated the complaint, and found the incident unfounded, however they did not report their investigation to the Director.

The failure to report the complaint investigation to the Director caused no harm to the resident.

Sources: The complaint report; policy titled, “Resident/Family Complaints Procedure,” revised October 2021; the home’s complaint documents; interview with the DOC, and other staff. [s. 23. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident’s money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A resident's Substitute Decision Maker (SDM) sent an email correspondence to the home which alleged neglect of the resident.

The Administrator verified that a critical incident was not submitted to the Director and the allegation should have been reported immediately.

The failure to not submit this allegation immediately to the Director caused no harm to the resident.

Sources: The home’s internal investigation notes, email correspondence from a resident's SDM, a resident health's care records, the home's policy titled “Prevention and Abuse and Neglect of a resident"; interviews with the acting Administrator, the DOC, and other staff. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was bathed, at a minimum twice a week, by the method of their choice.

A resident's care plan identified their preferred method of bathing; however, they were provided with an alternate method of bathing.

The resident receiving a bed bath instead of a shower caused minimal harm to the resident.

Sources: interviews with PSWs, RPNs and DOC; record review, a resident's care plan, Point of Care tasks, home’s policy titled, “Hygiene, Personal Care [and] Grooming”. [s. 33. (1)]

Issued on this 20th day of May, 2022

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

Original report signed by the inspector.