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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date September 12, 2022
Inspection Number 2022_1429_0002
Inspection Type
☐ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long-Term Care Home and City
Woodbridge Vista Care Community, Woodbridge

Lead Inspector
Joy Ieraci (665)

Additional Inspector(s)
Kim Lee (741072) was present during the inspection.

Inspector Digital Signature
Maria Joy Ieraci
Digitally signed by Maria Joy Ieraci
Date: 2022.09.13 14:07:47 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 30 and 31, September 1, 2, 7 and 8, 2022.

The following intake(s) were inspected:

- Log #012192-22 (Complaint) related to the care of a resident;
- Log #015613-22 (Follow-up) related to air temperatures and;
- Log #015612-22 (Follow-up) related to cooling requirements.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 246/22	s. 24 (2) 3	2022_1429_0001	001	Joy Ieraci (665)
O. Reg. 246/22	s. 23 (4)	2022_1429_0001	002	Joy Ieraci (665)

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.102(8)

The licensee has failed to ensure that staff participated in the implementation of the home's infection prevention and control (IPAC) program related to personal protective equipment (PPE).

Rationale and Summary

A resident was on droplet and contact precautions. The droplet and contact precautions signage posted at the resident's door directed staff to wear PPE of a gown, gloves and procedure mask with eye protection when within two metres of the resident.

A personal support worker (PSW) provided resident care and was within two metres of the resident when they provided and assisted the resident with their meal tray. The PSW was wearing a procedure mask without eye protection at the time of the observation.

IPAC Lead confirmed that the PSW did not wear the appropriate PPE when care was provided to the resident.

There was no risk to the resident, but there was a risk of infection transmission to other residents and staff when the appropriate PPE for droplet and contact precautions was not worn by the PSW.

Sources: Resident care observation, review of the resident's clinical records and Droplet and Contact Precautions Signage, and interviews with the PSW and IPAC Lead.

[665]

WRITTEN NOTIFICATION COMPLAINTS PROCEDURE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s.26(1)(c)

The licensee has failed to ensure that the written complaint received concerning the care of a resident was immediately forwarded to the Director.

Rationale and Summary

The home received a written complaint regarding the care a resident received in the home. The written complaint was not forwarded to the Director until 23 days later.

The Assistant Director of Care (ADOC) confirmed that the written complaint was not forwarded to the Director immediately.

Sources: Record review of the critical incident report and written complaint, and interview with the ADOC.

[665]

WRITTEN NOTIFICATION DOORS IN A HOME

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.12(1)3

The licensee has failed to ensure that all doors leading to non-residential areas were closed and locked when they were not being supervised by staff.

Rationale and Summary

The doors leading to outdoor balconies in the television (TV) lounges in two resident home areas were open and unlocked. There were two mobile residents in one TV lounge at the time of the observation.

Two staff members indicated that the balconies were non-residential areas, and the doors were to be closed and locked when not supervised by staff.

There was a risk of injury to the two mobile residents if they attempted to enter the outdoor balcony unsupervised.

Sources: Resident home area observations, and interviews with the PSW and registered practical nurses (RPNs).

[665]