Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 26, 2023	
Inspection Number: 2022-1429-0003	
Inspection Type: Critical Incident System (CIS)	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Woodbridge Vista Care Community, Woodbridge	
Lead Inspector Kehinde Sangill (741670)	**Inspector Digital Signature** Kehinde U Sangill Digitally signed by Kehinde U Sangill Date: 2023.02.01 16:25:47 -05'00'
Additional Inspector(s) Nital Sheth (500)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 15, 19-23 and 28, 2022.

The following intake(s) were inspected:
- Intake #00014653 (CIS#2945-000079-22) related to falls prevention and management;;
- Intake #00015172 (CIS#2945-000083-22) related to transferring and positioning techniques;
- Intake #00012286 (CIS#2945-000067-22) related to reporting and complaints;
- Intakes #00014446 (CIS#2945000074-22), #00003387 (CIS#2945-000043-21) and #00013431 (CIS#2945-000074-22) were related to duty to protect.

The following intakes were completed in this Critical Incident System (CIS) inspection:
- Intakes #00001725 (CIS#2945-000067-21); #00002436 (CIS#2945-000058-21); #00003088 (CIS#2945-000060-21); #00003407 (CIS#2945-000052-22); #00003544 (CIS#2945-000004-22); #00003549 (CIS#2945-000059-21); #00003552 (CIS#2945-000008-21); #00005827 (CIS#2945-000054-22); #00006466 (CIS#2945-000035-22); #00007689 (CIS#2945-000031-22) and #00011919 (CIS#2945-000066-22) were related to falls prevention and management;
- Intakes #00001588 (CIS#2945-000037-22) and #00007366 (CIS#2945-000056-22) were related to transferring and positioning techniques.

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

Prevention of Abuse and Neglect
Responsive Behaviours
Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that a policy directive that applied to the long-term care, the Minister's Directive: Coronavirus Disease 2019 (COVID-19) response measures for long-term care homes, was complied with.

In accordance with the directive, the licensee was required to follow measures outlined in the Ministry of Long-Term Care (MLTC) COVID-19 Guidance Document for Long-Term Care Homes (LTC) in Ontario. The document required that all residents were assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.

Rationale and Summary

Within a period of one month, temperature checks were not documented for two days for a resident. During this period, the home was experiencing respiratory and COVID-19 outbreaks.

A Registered Practical Nurse (RPN) and the Infection Prevention and Control (IPAC) lead acknowledged that the temperature checks for COVID-19 infection monitoring were not completed for the resident on those two days.

Failure to follow measures outlined in the MLTC COVID-19 guidance document for LTCH during an outbreak can result in the delay of identifying infections and taking appropriate actions.

Sources: Minister's Directive: COVID-19 response measures for long-term care homes dated August 30, 2022; Ministry of Long-Term Care COVID-19 Guidance Document for Long-Term Care Homes in Ontario, updated December 23, 2022; Resident's clinical records; interview with an RPN and IPAC Lead. [741670]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan, related to falls interventions.

Rationale and Summary

The resident was at risk of falls and the plan of care included a particular intervention to decrease their risk of injury related to falls.

The resident was observed sitting in a wheelchair and the intervention was not in place.

A RPN verified that staff did not follow the instruction as indicated in the plan of care.

Failure to ensure the care set out in the plan of care for the resident put them at risk of injury in the event of a fall.

Sources: Resident observation; review of resident's clinical records; interviews with the RPN and other staff. [741670]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to document the provision of care related to Dementia Observation System (DOS) monitoring in the plan of care for a resident.

Rationale and Summary

One resident pushed another resident and caused them to fall. DOS monitoring was initiated to monitor the responsive behaviour of the aggressor.

DOS monitoring records were missing for four evenings out of a 12-day period.

The Director of Care (DOC) verified that the staff were required to complete the DOS record while the resident was on DOS monitoring.

Sources: Review of the CIS report, resident's clinical records, and interview with DOC. [500]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The licensee has failed to protect a resident from physical abuse by another resident.

Rationale and Summary

According to O. Reg. 79/10, s. 2 (1), “physical abuse” means, subject to subsection (2), "the use of physical force by a resident that causes physical injury to another resident".

A resident bit another resident causing injury and pain.

The home’s policy on abuse and neglect indicated that the home has a zero tolerance of abuse, and abuse of a resident will not be tolerated under any circumstance.

The RPN verified the above mentioned incident as physical abuse from the first resident to the second identified resident, as it resulted in an injury.

The RPN and the DOC verified that the above incident constituted resident to resident physical abuse resulting from a resident’s responsive behaviour.

Sources: Review of CIS report, Home’s policy on Prevention of Abuse and Neglect of a Resident (VII-G-10.00, revised October 2022), residents' progress notes, interview with RPN and others. [500]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 40

The licensee has failed to ensure that staff used safe transferring and positioning techniques for a resident.

Rationale and Summary

The home submitted a CIS report to the MLTC in 2022, for an injury sustained during a transfer.

The resident required a mechanical device with two staff total assistance for transfers.

A Personal Support Worker (PSW) attempted to transfer the resident alone from wheelchair to bed using a mechanical device. The resident was hit on the head by the device and sustained an injury during the transfer.

A PSW and RPN verified that the resident required a mechanical device with two-person total transfer at the time of the incident.

Failure of staff to use safe transferring techniques resulted in injury to the resident.

Sources: Review of CIS report; the LTCH's investigation notes; review of resident's clinical record; interviews with the PSW, RPN and other staff. [741670]

WRITTEN NOTIFICATION: EVALUATION OF PREVENTION OF ABUSE AND NEGLECT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 106 (e).

The licensee has failed to provide a written record of the home's evaluation made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary

The DOC confirmed that they were unable to locate the written record of the home's evaluation of their zero tolerance of abuse and neglect policy for the year 2021.

Sources: Interview with the DOC [500]

COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

The Licensee has failed to comply with FLTCA, 2021, s. 24 (1)

The licensee shall:

Develop and implement strategies to monitor newly admitted residents in the home for a period of two months, in order to maintain their safety. The strategies shall include the following criteria:
(a) to protect residents from physical abuse by residents exhibiting responsive behaviours.
(b) keep and maintain a written record of the above.

The licensee has failed to protect a resident from physical abuse by another resident.

Grounds

According to O. Reg. 246/22, s. 2 (1), “physical abuse” means, subject to subsection (2), "the use of physical force by a resident that causes physical injury to another resident".

A PSW found a resident on the floor in the hallway. The PSW reported the incident to the RN. The RN completed an assessment and documented good range of motion (ROM) in all extremities; no injuries were identified. The resident was agitated and refused a head to toe assessment. An hour and 15 minutes later, the resident was identified with limited ROM, and pain in an arm and a leg. The resident was transferred to the hospital and passed away ten days later.

During the investigation, the home identified from the camera footage that an identified resident pushed the resident when the first resident entered their room. The second resident had a prior history of responsive behaviour where they pushed another resident.

The inspector verified the incident based on a review of the camera footage provided by the home.

The Coroner indicated that the resident’s cause of death included a result of complications of surgery and sequencing event of a fall.

The home’s policy on abuse and neglect indicated zero tolerance of abuse and neglect, and abuse of a resident will not be tolerated by anyone under any circumstance.

The DOC verified the incident and confirmed that the home’s investigation substantiated the abuse of the first resident by the second resident.

Failure to manage one resident’s responsive behaviour resulted in harm to a resident.

Sources: Review of CIS report, Policy on Prevention of Abuse and Neglect of a Resident (VII-G-10.00, revised October 2022), home’s investigation notes, and interview with the Coroner, DOC, and others. [500]

This order must be complied with by March 28, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021, s. 24 (1)

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

- Order #001 of inspection 2021_769646_0011, LTCHA, s. 19 (1)
- Order #003 of inspection 2020_780699_0014, LTCHA, s. 19 (1)

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 IPAC PROGRAM

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (8)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

The Licensee has failed to comply with O.Reg. 246/22, s. 102 (8)

The license shall:

(a) Retrain six identified staff regarding the use of personal protective equipment (PPE) required for the care of residents on additional precautions, and on donning and doffing PPE in the course of performing their respective duties;

(b) Retrain all staff, students and volunteers on hand hygiene practices in accordance with Public Health Ontario "Just Clean Your Hands" program;

(c) Audit hand hygiene practices on two identified resident home areas (RHA) for three weeks and include day, evening, and night shifts in the audits;

(d) Maintain a record of the aforementioned training, including the dates, staff names and designation, signed attendance, training topics, and name and title of the person(s) who provided the training;

(e) Maintain a record of the aforementioned audits, including the dates and times of the audits, the name(s) of the auditor, the names and designation of staff audited, results of audits and actions taken.

(i) The licensee has failed to ensure that staff participated in the implementation of the home's IPAC program related to the use of PPE.

Grounds

Three identified staff members were observed interacting with residents on additional precaution in a COVID 19 outbreak unit without wearing the required PPE.

On another occasion, housekeeping staff were observed inputting the door code to leave a COVID 19 outbreak unit while wearing disposable gloves used for cleaning. The IPAC lead acknowledged that housekeeping staffs ought to have removed their gloves and performed hand hygiene immediately after completing their task.

On two separate observations, a screener was not wearing required PPE while screening visitors and performing COVID 19 rapid antigen tests.

The IPAC lead acknowledged that staff are expected to perform hand hygiene upon entering or leaving residents' rooms and when they change PPE.

Staff failure to perform hand hygiene during an outbreak increased the risk of spreading infection in the home.

Sources: Observations related to the home's IPAC practices; interviews with a screener, housekeeping staffs, IPAC lead and other relevant staff. [741670]

(ii) The licensee has failed to ensure that staff participated in the implementation of the home's IPAC program related to hand hygiene.

Grounds

Four identified staff members were observed entering and exiting residents' rooms without performing hand hygiene. Three of the residents' rooms were on additional precaution in a COVID-19 outbreak unit. In a video footage provided by the home, two PSWs were observed removing PPE without performing hand hygiene.

The home's hand hygiene policy stated that all team members/volunteers/visitors will practice hand hygiene before initial resident environment contact, after resident environment contact and after removing any PPE.

The IPAC lead acknowledged that staff are expected to perform hand hygiene upon entering or leaving residents' rooms and when they change PPE.

Staff failure to perform hand hygiene during an outbreak increased the risk of spreading infection in the home.

Sources: Observations related to the home's IPAC practices; review of video footage provided by the home; review of Hand Hygiene Policy (IX-G-10.10, revised December 2021); interview with IPAC lead and other relevant staff. [741670]

This order must be complied with by February 28, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with O. Reg. 246/22, s. 102 (8)

Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

- Order #008 of inspection 2020_780699_0014, O. Reg. 79/10, s. 229 (4)

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.