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

Original Public Report

Report Issue Date: March 21, 2023

Inspection Number: 2023-1429-0004

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

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

Lead Inspector	**Inspector Digital Signature**
Henry Chong (740836)	Henry A Chong Digitally signed by Henry A Chong Date: 2023.03.22 12:47:48 -04'00'

Additional Inspector(s)
Matthew Chiu (565)
Goldie Acai (741521)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
March 1-3, 6-10, 13, 2023

The following intake(s) were inspected:

- Intake: #00003380 - [CI: 2945-000024-21] Resident to resident physical abuse
- Intake: #00003408 - [CI: 2945-000033-21] Staff to resident neglect
- Intake: #00003546 - [CI: 2945-000029-21] Staff to resident physical abuse
- Intake: #00003606 - [CI: 2945-000012-21] Staff to resident physical abuse
- Intake: #00003674 - [CI: 2945-000048-21] Staff to resident physical abuse
- Intake: #00006134 - [CI: 2945-000056-21] Fracture etiology unknown
- Intake: #00016866 - [CI: 2945-000088-22] Unexpected death
- Intake: #00019405 - Follow-up related to Infection Prevention and Control
- Intake: #00019849 - [CI: 2945-000007-23] An emergency, including fire, unplanned evacuation or intake of evacuees
- Intake: #00020089 - [CI: 2945-000008-23] Fall with injury
- Intake: #00021797 was a complaint related to pest control

The following intake(s) were completed in this inspection:

- Intake: #00018671 - [CI: 2945-000001-23] Fall with injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2022-1429-0003 related to O. Reg. 246/22, s. 102 (8) inspected by Henry Chong (740836)

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that their hand hygiene program was implemented in accordance with any standard issued by the Director.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary
On an identified date, two bottles of 62% ABHR were observed in a home area. The IPAC Lead and a

staff member were informed and discarded the product. The IPAC Lead acknowledged that the product should not be used and confirmed that hand hygiene agents with a minimum of 70% alcohol should be used in the home. There was risk to residents as ABHR under 70% may be ineffective in killing pathogens.

Sources: Observations; and interviews with staff and IPAC Lead.

[740836]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 20 (1)

The licensee has failed to comply with the procedure to report witnessed or suspected abuse of a resident immediately.

In accordance with O. Reg 79/10 s. 8 (1) b, the licensee is required to ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents in place, and the policy must be complied with.

Specifically, staff did not comply with the home's policy "Prevention of Abuse and Neglect of a Resident, VII-G-10.00" last revised October 2022 which was captured as part of the licensee's Zero Tolerance policy for abuse of a resident by anyone.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
The licensee's policy "Prevention of Abuse and Neglect of a Resident" directed staff to immediately inform the nurse in charge of any witnessed or suspected abuse of a resident.

On an identified date, a staff member informed the interim Director of Care (DOC) that there was an allegation of physical abuse from another staff member to the resident.

The staff member acknowledged they are to inform the nurse and report the suspicion of abuse immediately but did not. The DOC stated that the staff should have reported this to the nurse

immediately as per the home's policy.

Sources: Critical Incident System (CIS) report #2945-000012-21; licensee's policy "Prevention of Abuse & Neglect of a Resident, VII-G-10.00" last revised October 2022; and interviews with the DOC and other staff.

[740836]

WRITTEN NOTIFICATION: Duty to protect

NC #003 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 neglect by staff.

According to O. Reg 79/10 "neglect" means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
The resident had health conditions which limited their ability to adequately clear orally ingested items such as food, medications and fluid. The resident required assistance with oral care. During identified dates, the resident required additional assistance with oral care which was not provided. Staff members indicated additional oral hygiene should have been implemented.

Failure to provide the resident with additional oral hygiene assistance resulted in deteriorating oral health and infection.

Sources: Interviews with staff; resident's care plan, progress notes, orders; Policy on Prevention of Abuse and Neglect of a Resident VII-G-10.00, revised October 2022.

[741521]

WRITTEN NOTIFICATION: Plan of care

NC #004 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 resident #005 and #006's plan of care was provided to the residents as specified in the plan.

Rationale and Summary
a) Resident #005 had a fall and was transferred to the hospital and diagnosed with an injury. The resident's plan of care specified the use of a piece of protective equipment as an intervention to decrease their risk of injury related to falls.

On the date of the fall, the above mentioned intervention was not provided to the resident as specified in the plan. Staff interviews indicated that the intervention should have been offered to the resident and if they refused, staff would have to report to the nurse so that a follow up action could be taken.

There was greater risk of injury to resident #005 when the intervention was not provided.

Sources: Resident's care plan; home's investigation records; and interviews with staff.

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Rationale and Summary
b) Resident #006's plan of care indicated that an intervention was to be in place when they were in the wheelchair for falls prevention.

On an identified date, multiple observations and staff interviews confirmed that when resident #006 was in their wheelchair, the intervention was not in place. Failure to provide the intervention to resident #006 increased the risk of the resident falling.

Sources: Resident's care plan; observations; and interviews with staff.

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WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)

The licensee has failed to ensure that staff who provided direct care to resident were kept aware of the contents of the resident's falls prevention plan of care.

Rationale and Summary
The resident's plan of care indicated that an intervention was in place for falls prevention.

A staff member stated that the resident no longer required the intervention for falls prevention and was not aware it was included in their plan of care. The non-compliance caused a risk for preventing resident's falls.

Sources: Resident's care plan; and interviews with staff.

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COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #006 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)]: The licensee shall:

1. Re-educate two identified staff on the home's hand hygiene policy and the four moments of hand hygiene;

2. Re-educate identified staff regarding the home's masking policy;

3. Re-educate two identified staff on donning and doffing PPE in the course of performing their respective duties with respect to residents on additional precautions;

4. Maintain a record of the education provided, including the content of the material reviewed, the date completed, and the staff member who provided the education;

5. Conduct daily audits of hand hygiene practices and the use of PPE for all home areas, for a period of three weeks following the service of this order;

6. Maintain a record of the audits, including the date, result of each audit, the staff member who conducted the audit, and the actions taken in response to the audit findings.

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

Rationale and Summary

a) On an identified date, a staff member was observed entering and leaving multiple resident rooms without performing hand hygiene. The staff member was aware of the four moments of hand hygiene, but stated they were busy with the task at hand and forgot to perform hand hygiene. The home's policy 'Hand Hygiene' IX-G-10.10, instructs staff to use alcohol-based hand rub before entering and after leaving resident rooms, in addition to the four moments of hand hygiene.

b) On another identified date, a staff member was observed in a resident's room with droplet contact precaution requirements, including mask, gown, eye protection and gloves. Staff was assisting the resident and was observed wearing a gown, face mask and shield, but no gloves. When asked why staff was not wearing gloves, the staff member without performing HH proceeded to obtain gloves located outside the resident room. Staff member then proceeded to don gloves without performing hand hygiene. The home's policy 'Hand Hygiene IX-G-10.-10' last revised April 2022, instructs staff to perform hand hygiene before donning gloves, in addition to all team members practicing hand hygiene in accordance with the four moments of hand hygiene and as needed.

c) On an additional date, a staff member was observed sitting between two residents with adjoining chairs with their mask below their nose speaking to two co-workers. The staff member acknowledged they were not following the masking policy within the home and was aware that this action increases the risk to spreading infectious disease to residents.

Sources:

Observations of staff members; interviews staff members; Policy Hand Hygiene IX-G-10.-10 last revised April 2022, IPAC standard for Long-Term Care Homes last revised April 2022, and Universal Masking Policy (Covid-19) (ON), IX-N-10.48 last reviewed April 2022.

[741521]

d) On an identified date, a staff member was observed entering a resident's room that was under droplet/contact precautions. A droplet/contact precautions sign was posted on the door indicating the specific personal protective equipment (PPE) to be worn by staff. The staff member wore a mask, gloves, and gown prior to entering the room, but did not wear eye protection.

The staff member and the IPAC Lead stated that they are to wear eye protection, mask, gloves, and gown when entering a room under droplet/contact precautions. The IPAC lead stated that staff are expected to follow the signage regarding PPE requirements for residents on additional precautions. There was increased risk of transmission of infection to staff and residents.

Sources:
Inspector's observations; and interview with IPAC Lead and other staff.

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Failure to select and use appropriate PPE as per the isolation requirements, failing to perform hand hygiene at minimum using the four moments of hand hygiene, and failing to use face mask as directed by policy increases the risk of disease transmission.

This order must be complied with by May 2, 2023

This Compliance Order is being referred to the Director for further action by the Director.

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
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 $11000.00, 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 #002 of inspection 2022_1429_0003, O. Reg. s. 246/22, s. 102 (8)

This is the second 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.