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:** May 30, 2023

**Inspection Number:** 2023-1429-0005

**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** |
|---|---|
| Manish Patel (740841) | Manishkumar C Patel Digitally signed by Manishkumar C Patel Date: 2023.06.05 13:09:19 -04'00' |

**Additional Inspector(s)**
Kehinde Sangill (741670)
Irish Abecia (000710)
Dorothy Afriyie (000709)
Noreen Frederick (704758)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 4, 5, 8 - 12, 15 - 19, 24, 2023
The inspection occurred offsite on the following date(s): May 23, 2023

The following intakes were completed in this complaint inspection:

- Intake: #00022613 – regarding retaliation, COVID-19 outbreak, IPAC, recreational and social activities, dining and snack service, alleged neglect and potential physical abuse, bathing, training, improper transferring.
- Intake: #00086047 - regarding bathing, potential neglect related to continence care, direct hours of care, nursing and personal

The following intakes were completed in this follow-up inspection:

- Intake: #00019404 and Intake: #00084095 were follow-ups to previously issued Compliance Orders

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00006916 - [CI: 2945-000012-22] and Intake: #00010824 - [CI:2945-000063-22] related to unknown cause of injury to a resident.
- Intake: #00007326 – [CI: 2945-000051-22], Intake: #00085473 - [CI: 2945-000032-23] and Intake: #00086612 - [CI: 2945-000036-23] related to fall resulting in injury.
- Intake: #00022771 - [CI: 2945-000020-23] related to alleged verbal abuse.
- Intake: #00084236 - [CI: 2945-000023-23] related to an episode of severe hypoglycemia that required transfer to hospital.
- Intake: #00084358 - [CI: 2945-000024-23] related to resident to resident physical abuse.
- Intake: #00086193 - [CI: 2945-000034-23] related to alleged abuse and neglect, staffing shortages, continence care, and bathing.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1429-0003 related to FLTCA, 2021, s. 24 (1) inspected by Noreen Frederick (704758)

Order #001 from Inspection #2023-1429-0004 related to O. Reg. 246/22, s. 102 (8) inspected by Kehinde Sangill (741670)

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

Resident Care and Support Services
Continence Care
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Recreational and Social Activities
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Duty To Protect

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect resident #008 from physical abuse by resident #007.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident; (“mauvais traitements d’ordre physique”)”.

**Rationale and Summary**
A Critical Incident (CI) report was submitted for an altercation between resident #007 and #008. In this altercation, resident #008 was physically abused by resident #007.

Resident #008 was present at the nursing station and resident #007 was walking in the hallway. Resident #007 approached resident #008 and attempted to assist the resident. This attempt to assist was resisted by resident #008 and in response to this, resident #007 struck resident #008 before staff could intervene. The incident was witnessed by a Personal Support Worker (PSW) .

Failure to prevent abuse resulted in injury to resident #008.

**Sources:** Interview with PSW and Director of Care (DOC) , review of CIS report.
[740841]

## WRITTEN NOTIFICATION: Bathing

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The Licensee has failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice on two occasions in one week.

**Rationale and Summary**
The resident's family had complained to the licensee that the resident had not received a shower as the resident's hair appeared soiled during a visit.

The resident's method of choice for bathing was shower.

The home's investigation identified that the shower was under repair in identified time frame. The resident was scheduled to have two showers during this time frame. Instead of shower, another mode of bathing was provided to the resident. The change in the plan was not communicated to the family.

Failure to provide a shower, which was the bathing method of choice for the resident increased the risk of hygiene issues.

**Sources:** Interview with Associate Director of Care (ADOC) #112, DOC, Executive Director (ED), Review of complaint response letter.
[740841]

## WRITTEN NOTIFICATION: Oral Care

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 38 (2)

The licensee has failed to ensure that one resident received assistance to have a device to assist with meals, prior to meals as required by the resident's plan of care.

**Rationale and Summary**
The resident required an adaptive device to promote independence with eating. On identified date, the resident was observed eating meals without this device. A PSW acknowledged they were aware that the resident required this device to eat but forgot to assist prior to serving meals.

Failure to provide device prior to meals for the resident put them at risk of difficulty eating and poor intake.

**Sources:** Observation; resident's clinical record and interview with PSW.
[741670]

## WRITTEN NOTIFICATION: Dealing With Complaints

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the written responses on identified dates, provided to a person who made a complaint to the licensee concerning the care of a resident, included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

**Rationale and Summary**
Written concerns regarding the care of a resident were received by the licensee on identified dates. These concerns were responded in writing by the home.

The response letters did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

**Sources:** Review of the response letters. Interview with DOC, ED.
[740841]

## WRITTEN NOTIFICATION: Administration of Drugs

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

**Rationale and Summary**
The resident had prescribed timing and directions for administration of certain medications.

During observation of the resident medication administration, all their prescribed medications were administered three hours late.

Registered Practical Nurse (RPN) indicated that all scheduled medications should be administered two hours of prescribed time. The RPN acknowledged they did not follow the physician's orders when they administered the medications at the wrong time.

Failure to administer the resident's medications at the time specified by the prescriber increased the risk of medications not providing the desired effect.

**Sources:** Observation of medication administration to the resident, review of resident's clinical records, interview with RPN.
[741670]

## COMPLIANCE ORDER CO #001 Plan of Care

**NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: FLTCA, 2021, s. 6 (7)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:

1. Conduct five random audits weekly of residents who require two-person assistance for ADLs related to incontinence care. These audits should be conducted for a minimum of four weeks, or until no further concerns are identified with staff practice.
2. Maintain a documented record of audits conducted, to include but not be limited to: date of audit, resident name, staff name(s), ADL type and level of assistance required, results of the audit and any corrective action taken in response to the audit.
3. Conduct once-daily audits for a period of two weeks following the service of this order of the provision of identified falls prevention intervention to an identified resident.
4. Maintain a documented record of audits conducted, to include but not be limited to: date of audit, resident name, staff name(s), whether identified falls prevention intervention was applied or not and any corrective action taken in response to the audit.

**Grounds**

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 related to Activities of Daily Living (ADL), resident #011 related to toileting and hygiene, and falls prevention interventions, resident #015 related to meals times and resident #013 related to their shower schedule, as specified in the plan.

**(1) Rationale and Summary**

A resident's care plan indicated that they required two-person assistance for their ADLs.

A PSW stated that they provided care to resident by themselves the on the day of incident. The resident fell and sustained injuries. The DOC acknowledged that the resident was not provided with two-person assistance as specified in their care plan.

Failure to ensure that the resident was provided with care as set out in their care plan, resulted in the resident sustaining injuries.

**Sources**: Resident's care plan, progress notes, and interviews with PSW, RPN and DOC.
[704758]

**(2) Rationale and Summary**

A resident's care plan directed staff to provide identified eating adaptive aide and particular type of juice at meals. At lunch on identified date, the resident was not provided these interventions.

The Food Service Supervisor (FSS) verified that the specific type of juice was not served to the resident at meals and PSW verified that resident's food was not served with required adaptive aid.

A PSW acknowledged they did not follow the care plan. RPN also acknowledged the staff did not follow the resident's care plan.

Failure to provide required beverages and adaptive aids may negatively impact the resident's independence and fluid intake.

**Sources:** Mealtime observation; resident's clinical record, and interviews with PSW, RPN and other staff.
[741670]

**(3) Rationale and Summary**

The resident's care plan directed staff to provide shower before a particular meal.

On an identified date, staff provided shower for the resident after the specified meal.

A PSW stated that they were behind in their duties due to providing assistance to other residents and staff. The PSW acknowledged that they did not follow resident's care plan when they provided their shower after the specified meal.

There was no risk to the resident from as they received assistance with bathing after the specified meal.

**Sources:** Observation of the resident; review of resident's care plan, interviews with PSW. [741670]

**(4) Rationale and Summary**

On identified date, a resident had an unwitnessed fall and sustained injury. The resident required two-person assistance for toileting and personal hygiene.

PSW #106, #107, #109 and #117 stated that they provided toileting and hygiene assistance by themselves on different occasions to the resident. An RPN confirmed that the resident required two-person assistance for toileting and personal hygiene.

ADOC #112 acknowledged that staff did not follow the care plan.

On multiple occasions staff provided one-person care to the resident, placing resident at risk for further falls and subsequent injuries.

**Sources:** Interview with PSW #106, #107, #109, #117, Review of resident care plan, Kardex. POC [000709]

**(5) Rationale and Summary**

A resident was to be provided with specific aid as a fall prevention intervention. When observed, the resident did not have this intervention in place to prevent falls.

A PSW did not use the specific aid to prevent falls and acknowledged that they were not aware of fall prevention interventions. Both, PSW and RPN acknowledged that not using the identified intervention as specified in the care plan could increase the risk of falls.

Not having identified aid to prevent falls, put the resident at risk of further falls.

**Sources:** Observation, Interview with PSW, and RPN. Review of resident care plan and Kardex. [000709]

**This order must be complied with by**

July 7, 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

**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 $1100.00, 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:**

Compliance Order (CO) #001 under inspection 2020_769646_0019 was issued to LTCHA, 2010, s. 6 (7).

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.