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: October 12, 2023	
Inspection Number: 2023-1429-0007	
Inspection Type: Complaint Critical Incident	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Villa Santa Maria Community, Woodbridge	
Lead Inspector Parimah Oormazdi (741672)	**Inspector Digital Signature** Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2023.10.18 12:18:44 -04'00'
Additional Inspector(s) Kirthiga Ravindran (000760) Adelfa Robles (723)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 5-8, 11-13, 2023

- Intake: #00093713 (complaint) was related to falls prevention and management.
- Intake: #00093707 (complaint) was related to falls prevention and management.
- Intake: #00093789 (complaint) was related to falls prevention and management.
- Intake: #00093747/ Critical Incident (CI) #2945-000059-23 was related to falls prevention and management.
- Intake: #00095000/ CI #2945-000063-23 was related to injury of unknown cause.
- Intake: #00095313/ CI #2945-000064-23 was related to Infection Prevention and Control (IPAC).

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

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 the Infection Prevention and Control lead (IPAC lead) carried out their responsibilities related to the hand hygiene program.

The IPAC lead failed to ensure that there is in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the IPAC lead did not ensure that the hand hygiene program includes 70-90% alcohol-based hand rub as is required by Additional Requirement 10.1 under the IPAC Standard.

Rationale and Summary
An expired hand sanitizer product was found on one of the home areas. A Registered Practical Nurse (RPN) acknowledged that the product was expired and would not be effective. The IPAC lead acknowledged expired hand sanitizer products should have been removed and might not be effective.

A Personal Support Worker (PSW) was observed utilizing a paper towel when providing hand hygiene to a resident after meal service and then drying the resident's hands with a dry paper towel. The IPAC lead acknowledged that residents are required to have hand hygiene before and after meals and that the PSW did not provide effective hand hygiene.

Failure to ensure the hand hygiene program was implemented during an outbreak increased the risk of transmitting infection in the home.

Sources: Observation, interview with an RPN, PSW and the IPAC lead, Home's Hand Hygiene Policy, IPAC Standard for Long Term Care Homes April 2022.
[000760]

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

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

The license shall:
1. Retrain two PSWs and an RPN regarding the use of Personal Protective Equipment (PPE) required for the care of residents on additional isolation precautions and on donning and doffing PPE.
2. Retrain a PSW on hand hygiene practices in accordance with the home's hand hygiene program.
3. Audit hand hygiene practices on one of the home areas for a certain time period and include day, evening, and night shifts in the audits.
4. 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.
5. 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.

Grounds
The licensee has failed to ensure that a standard with respect to infection prevention and control was implemented.

Rationale and Summary
The licensee has failed to fully implement an IPAC program in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022". Specifically, the proper use of PPE, including appropriate selection, application, and removal as is required by Additional Requirement 9.1 (d) under the IPAC Standard.

Personal Protective Equipment Policy stated that PPE should be donned in this order: perform hand hygiene, put on gown, put on mask/ N95 respirators (for respirators, perform a seal-check), don protective eyewear, put on gloves. Personal Protective Equipment Policy stated that PPE should be taken off in this order, remove gloves, remove gown, perform hand hygiene, remove eye protection, remove mask/N95 respirator, perform hand hygiene.

(a) An observation was conducted on a confirmed outbreak unit. Two residents were on Droplet Contact Precautions (DCP) requiring staff to wear the following PPE: gown, gloves, N95 mask, and face shield upon entering a room. A PSW entered the residents' room without an N95 mask or face shield to

provide meal tray service. The PSW acknowledged they were not wearing the required PPE for residents on DCP. The PSW was observed leaving one of the resident's rooms doffing PPE in the following order: gloves, surgical mask, gown then completed Hand Hygiene (HH). The PSW acknowledged that they did not doff PPE in the correct order. The IPAC lead acknowledged that staff were expected to wear an N95 mask when entering resident rooms on DCP and to remove their PPE in the following order gloves, gown, HH, eye protection, mask.

(b) In one of the home areas, a PSW was observed donning PPE prior to entering a room with signage on door advising of droplet contact precautions requiring gown, gloves, N95 mask and eye protection. The PSW was observed placing an N95 mask on top of a surgical mask prior to entering the room to feed the resident. The PSW acknowledged the appropriate PPE required an N95 mask and they had on a surgical mask and N95 mask. The IPAC lead acknowledged the PSW was not wearing the required PPE correctly while providing care to the resident. The Long Term Care Home's (LTCH's) PPE policy states that DCP requires staff to perform a seal-check when donning a respirator. Donning a surgical mask on top of an N95 respirator does not allow for the self-seal check to be completed as per policy.

(c) In one of the home areas, an RPN was observed wearing a surgical mask pulled down below their chin while on the phone at the nursing station. The entire home area was in an outbreak. The RPN acknowledged that a surgical mask was required to be worn when entering the unit and that they had not been wearing the mask effectively. The IPAC lead acknowledged that surgical mask was required in that home area and the RPN was not effectively wearing the surgical mask.

Failure of staff to adhere with PPE requirements during an outbreak compromised the long-term care home's infection control protocols and placed the home at risk of transmission of infectious agents.

Sources: Observations, interviews with two PSWs and the IPAC lead, review of Personal Protective Equipment Policy, IPAC Standard
[000760]

This order must be complied with by November 10, 2023

COMPLIANCE ORDER CO #002 PLAN OF CARE

NC #003 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 two random audits per each home area weekly of residents who were at high risk for falls requiring two-person assistance with the use of transferring equipment. These audits must be conducted for a minimum of four weeks.
2. Maintain a documented record of audits conducted, including but not be limited to: date of audit, resident name, staff name(s), fall prevention interventions in place at the time of audit and any corrective action taken in response to the audit.

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

Rationale and Summary
1) A resident's written plan of care indicated that they required multiple staff assistance for most of their Activities of Daily Life (ADLs).

Review of the home's video footage revealed that a PSW provided care to the resident on their own. The PSW confirmed that they provided care to the resident without partnering with another staff member. Two PSWs, an RPN, an Associate Director of Care (ADOC) and the Director of Care (DOC) all confirmed that the resident required multiple staff assistance with personal care and staff were expected to follow the residents plan of care.

2) The resident’s written plan of care indicated that they were at risk for falls. Resident had individualized falls intervention strategies in place to prevent falls.

The resident sustained a fall which resulted in injuries, and they deceased from complications of injuries.

Two PSWs confirmed that the resident's fall prevention interventions were not in place when the fall incident occurred.

The RPN, ADOC and DOC all stated that staff were expected to follow the resident's plan of care. The home completed an investigation and confirmed that staff did not follow the resident's plan of care as specified.

The resident sustained an injury when their plan of care was not followed as specified.

Sources: The resident's written plan of care, post fall assessments, Medical Certificate of Death, Home's investigation notes, video footage review, interviews with two PSWs, an RPN, an ADOC and the DOC. [723]

This order must be complied with by November 10, 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 #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $2200.00, 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:
2023-1429-0005 CO with $1100.00 AMPS
2022-1429-0003 WN
2022_891649_0003 WN & VPC

This is the second AMP that has been issued to the licensee for failing 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.