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: December 20, 2023
Inspection Number: 2023-1429-0009
Inspection Type: Complaint Critical Incident Follow up
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Villa Santa Maria Community, Woodbridge

Lead Inspector	Inspector Digital Signature
Parimah Oormazdi (741672)	Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2024.01.11 09:54:03 -05'00'

Additional Inspector(s)
Ramesh Purushothaman (741150)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 27-30 and December 1, 4-8, 2023

The following intakes were completed in this complaint inspection:

- Intake #00098644 was related to Infection Prevention and Control (IPAC)
- Intake #00099926 was related to improper transferring, pain management, plan of care, nutrition care and continence care
- Intake #00102951 was related to skin and wound care, communication and response system, missing personal items and responsive behaviors.

The following intakes were inspected during this Critical Incident (CI) Inspection:

- Intake: #00095780 / CI #2945-000065-23 was related to fall prevention and management program
- Intake #00098736 / CI #2945-000072-23 was related to IPAC

The following Compliance Order (CO) Follow up intakes were inspected:

- Intake: #00099322 - CO #001 under inspection #2023-1429-0007, O. Reg 246 / 22, s. 102 (2)(b) - IPAC; Compliance Due Date (CDD): November 10, 2023.
- Intake: #00099320 - CO #002 under inspection #2023-1429-0007, FLTCA, 2021, s. 6 (7), Plan of Care; Compliance Due Date (CDD): November 10, 2023.

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

- Intake #00096792 / CI #2945-000066-23 and intake #00098345 / CI #2945-000070-23 was related to fall prevention and management program

Previously Issued Compliance Order(s)

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

- Order #001 from inspection #2023-1429-0007 related to O. Reg 246 / 22, s. 102 (2)(b) inspected by Parimah Oormazdi (741672)
- Order #002 from Inspection #2023-1429-0007 related to FLTCA, 2021, s. 6 (7) inspected by Ramesh Purushothaman (741150)

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the fall prevention intervention that was set out in a resident's plan of care, was provided to the resident.

Rationale and Summary
A CI report was submitted to the Director related to a resident's fall that resulted in an injury. The resident's clinical records indicated that the resident had history of a multiple falls with injuries. Their care plan indicated that they were at high risk of falls, and they required to have fall prevention equipment in place. However, it was observed that the resident was sitting in their locomotion device while the fall prevention equipment was not applied to their locomotion device.

An Associate director of Care (ADOC) acknowledged the missing fall prevention device. The Director of Care (DOC) confirmed that all the fall prevention interventions should have been provided to the resident as indicated in their care plan.

Failure to provide fall prevention equipment to the resident as set out in their care

plan may put them at risk of injury following any fall incident in future.

Sources: Resident's clinical records, CI report, observation of resident, interviews with an ADOC and the DOC, home's "Falls Prevention & Management" policy, VII-G-30.10, last revised April 2023.
[741672]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)
Plan of care
Reassessment, revision
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The licensee has failed to ensure that the effectiveness of fall prevention intervention was assessed and different approaches were considered in the revision of a resident's plan of care.

Rationale and Summary
A resident had a fall when they were attempting to ambulate independently and no staff attended to assist the resident. Following the fall incident, they were transferred to hospital and diagnosed with an injury.

The Long-Term Care Home (LTCH)'s policy and procedure "Falls Prevention and Management - VII-G-30.10", indicates that " The preventative interventions should be monitored and their effectiveness should be evaluated on an ongoing basis and with the quarterly review."

The resident's clinical records indicated that they required extensive staff assistance for a specific daily activity, they were at risk of falls and had fall prevention intervention added in their plan of care. However, the a fall occurred in spite of the fall prevention device being utilized. There were no records identified to indicate the fall prevention intervention was reassessed for effectiveness and different approaches were taken if it was not effective.

Two Personal Care Workers (PSWs) indicated that they were not alerted by the fall prevention equipment to attend the resident when they got out of bed. They also stated that they were not alerted by the device when they were not close to the resident's room or when they were providing care in another resident's room. A Registered Practical Nurse (RPN) indicated that the device did not assist in making the staff aware of the resident's movement on bed. The DOC confirmed that the fall prevention intervention should have been reassessed and adjusted if it has not been effective for the staff to respond to resident's fall.

Failure to reassess the effectiveness of fall prevention interventions and taking different approaches in revision of resident #002's fall related plan of care placed the resident at risk of further falls.

Sources: Resident's clinical records, CI report, interviews with two PSWs, a RPN and the DOC, home's "Falls Prevention & Management" policy, VII-G-30.10, last revised April 2023, home's investigation notes.
[741672]

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 102 (2) (b)
Infection prevention and control program

s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246 / 22, s. 102 (2).

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 regarding the use of Personal Protective Equipment (PPE) required for the care of residents on additional isolation precautions and on donning and doffing procedures of PPE.
3. Audit donning / doffing PPE practices on two home areas for a specific period of time and include all shifts in the audits.
3. 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.
4. 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.

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 taken off in a specific order.

Rationale and Summary

(1) On a specific home area, a PSW was observed doffing PPE when they exited a resident's room with signage on door advising of droplet contact precautions requiring donning and doffing PPE including gown, gloves, mask and eye protection. The PSW did not complete the doffing steps appropriately and proceeded to another resident's room.

The PSW stated that they provided direct care to the resident with infection symptoms and they acknowledged they should have follow the doffing steps in a correct order when exiting the resident's room who was on droplet contact precautions. The IPAC lead confirmed that the PSW did not follow the doffing procedures of PPE correctly.

Sources: An observation, interviews with a PSW and the IPAC lead, review of Personal Protective Equipment Policy (IX-G-10.20 and IX-G-10.20 (a), revised March 2021), LTCH's Respiratory Outbreak Measures Checklist, section PPE, IPAC Standard [741672]

(2) On a specific home area, a PSW was observed to inappropriately remove their PPE, after providing care to a resident who was on droplet contact precautions. The PPE was removed in the following order: gloves, eye protection and gown. The PSW continued to wear the same mask and proceeded to provide care to a resident who was in the adjacent room.

The PSW acknowledged that they did not follow correct doffing sequence upon exiting the resident's room, after reading the proper doffing procedure posted on the door. They explained that they were expected to discard the mask and wear a new mask when exiting the resident room on droplet contact precautionary measures.

The IPAC lead acknowledged that the staff was expected to follow the correct donning and doffing procedures and to discard the contaminated mask upon exiting the resident's room.

There was a risk of infectious disease transmission when the correct doffing procedure was not followed.

Sources: Observations, interviews with a PSW and the IPAC lead.
[741150]

This order must be complied with by February 9, 2024

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 $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:
A Compliance Order (CO) was issued in inspection #2023-1429-0007

A Non Compliance Remedied (NCR) was issued in inspection #2022_1429_0001

This is the first 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.