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
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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: June 03, 2024

Inspection Number: 2024-1429-0003

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	**Inspector Digital Signature**
Adelfa Robles (723)	Adelfa P Robles Digitally signed by Adelfa P Robles Date: 2024.06.03 14:40:13 -04'00'

Additional Inspector(s)
Nrupal Patel (000755)
Slavica Vucko (210)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 13-17 and 21-24, 2024.

The following intake(s) were inspected:

- Intake #00108873/Critical Incident (CI) #2945-000006-24 – related to falls with injury.
- Intake #00114609/CI #2945-000018-24 – related to resident to resident physical abuse.
- Intake #00111518/CI #2945-000010-24 – related to a disease outbreak.

- Intake #00112705/CI #2945-000013-24; Intake #00113624 – complaint related to an incident resulting in a resident's hospitalization and subsequent death.
- Intake #00114589 and Log #00115073 – complaints related to multiple care concerns of residents.

The following intake(s) were completed:

- Intake #00113341/CI #2945-000015-24 and intake #00114497/CI #2945-000017-24 – were all related to fall with injury.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Falls Prevention and Management

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

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 a resident's falls interventions were provided as specified in the plan.

Rationale and Summary

A resident was at high risk for falls requiring intervention. The resident was observed with their fall intervention not in place.

Staff confirmed that the resident's fall interventions were not in place. The home stated that staff were expected to provide care as specified in their plan.

The resident was at risk for injury when their fall interventions were not in place.

SOURCES: Resident observations in the home, a resident's clinical records and staff interviews.

[723]

WRITTEN NOTIFICATION: Plan Of Care - Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

(1) The licensee has failed to ensure that care provided to a resident on specified dates were documented.

Rationale and Summary:

A resident's record indicated that staff to offer a particular beverage at a specified time of day. There was no documentation that a specific beverage was provided to a resident on specified dates.

Staff confirmed that the documentation was missing. The home stated that staff were expected to document care or services as provided to the resident.

There was no impact to a resident's health when the staff missed to document when a particular beverage was offered to a resident.

SOURCES: Residents clinical records and staff interviews.

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(2) The licensee has failed to ensure that care provided to a resident on specified dates were documented.

Rationale and Summary

A resident's records indicated that staff to provide a specific care to a resident as per their scheduled routine.

Review of the home's records indicated that there was no staff documentation that the scheduled care routine was provided to a resident on a specified date and times.

Staff confirmed that the documentation was missing. The home stated that staff were expected to document care or services as provided to the resident.

There was no impact to a resident's health when the staff missed to document when a particular beverage was offered to a resident.

SOURCES: Residents clinical records and staff interviews.

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was reassessed, and their plan of care was reviewed and revised when the care has not been effective related to their recreational activity.

Rationale and Summary

Clinical records indicated that a resident should have access to an identified product otherwise it may trigger aggressive behaviours.

An incident happened when the resident was deemed unsafe to use the identified product. A treatment was prescribed to the resident but was not tried or offered.

The home stated there was no reassessments completed for the resident to determine if they would agree to stop using the product or other interventions to use it.

Failure of the home to reassess a resident could have contributed to an escalation of their responsive behaviours.

SOURCES: Resident's clinical records and staff interviews.

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WRITTEN NOTIFICATION: CARE CONFERENCE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held

within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

The licensee has failed to ensure that a six-week care conference of the interdisciplinary team was held for a resident following admission to discuss the plan of care and any matters of importance to the resident and their substitute decision maker if any.

Rationale and Summary

A resident was admitted to the home on a specified date. Records review indicated that there was no care conference held for the resident six weeks post admission.

The home confirmed that the six weeks care conference post admission was not completed for the resident.

Failure of the home to conduct a six-week post admission care conference contributed to the resident and the family's wishes not being upheld.

SOURCES: Staff interviews, residents clinical records and home's records.

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