Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 24, 2020	2020_650565_0003	020826-19, 021338-19, 022196-19, 002525-20	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Woodbridge Vista Care Community
5400 Steeles Avenue West Woodbridge ON L4L 9S1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MATTHEW CHIU (565), NAZILA AFGHANI (764)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 10, 11, 12, 13, 14, 18, and 19, 2020.

The following intakes were completed in this Complaint Inspection:
- #020826-19, #022196-19, #002525-20 related to improper care of the residents and prevention of abuse and neglect, and
- #021338-19 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Director of Dietary Services (DDR), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Physiotherapist (PT), Maintenance staff (MS), Residents, and Family Members.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff involved in the different aspects of care of resident #005 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

A complaint was received by the Ministry of Long-Term Care (MLTC) on an identified date related to the care provided to resident #005 by the home.

Review of resident #005's health records indicated the resident had both cognitive and physical impairments. The resident’s plan of care stated the resident was at risk for a specified medical condition and had the identified interventions for the condition. On an identified date, resident #005 was transferred to the hospital and they were returned to the home on the next day. The hospital consultation records stated the resident had clinical correlation of the specified medical condition.

Interview with RPN #102 indicated the resident was transferred to the hospital due to the specified symptoms. At the hospital, they found that the resident had specified clinical findings and possibly the specified medical condition. The inspector reviewed resident #005's referral and assessment records with RPN #102 and identified no referral was sent to the RD for follow up after the resident returned to the home.

Interview with RD #103 indicated they were unaware that resident #005 was sent to the hospital with the clinical findings related to the specified medical condition. The RD stated that if the resident had the specified medical condition, registered staff should send them a referral to follow up. The RD did not receive any referral for assessing the resident’s specified care needs, and therefore had not assessed the resident.

Interview with the DDR indicated since the hospital record stated it shows clinical correlation of the specified medical condition, when the registered staff read the hospital report, they should have collaborated with the RD to follow up with the resident’s specified care needs. A dietary referral should have been sent to the RD for an assessment on the same day the resident returned to the home, but it was not until after the inspector brought to the staff’s attention during the staff interviews. The DDR acknowledged that the staff had not collaborated with each other in the assessment of resident #005’s specified care needs as required. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the incident in the home no later than one business day after the occurrence of the incident, subject to subsection (3.1), that caused an injury to resident #003 for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.
- (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of

the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

A complaint was received by the MLTC related to the care and reporting of resident #004's fall that occurred on an identified date.

Review of the CIS report indicated that resident #004 fell on the identified date and they were transferred to the hospital on the next day for further assessment. Two days later, the home was notified by the hospital that the resident had specified diagnoses. The CIS report was first submitted to MLTC 10 days after the occurrence of the fall.

Review of resident #004's health records stated the home followed up with the hospital and confirmed the resident's specified diagnoses on the identified date. The resident would be transferred to the unit and seen by the specified health care professionals as needed. The resident's functional mobility changes would be communicated once they were assessed.

Interview with the DOC indicated when the home followed up with the hospital regarding resident #004's health status, they were made aware of the resident's diagnoses. The DOC stated that based on the diagnoses, they were unable to determine if the resident's injury had resulted in a significant change in their health status and they were waiting for further assessments to determine. The home received another health status update five days after the original follow up and reported the incident two days later.

The DOC acknowledged that the Director was not informed of the above-mentioned fall no later than three business days after its occurrence, where the resident was being taken to the hospital and the home was unable to determine whether the injury had resulted in a significant change in resident #004's health condition at that time. [s. 107. (3) 4.]

Issued on this 24th day of February, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.