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
Aug 27, 2021	2021_784762_0023	008958-21, 008959-21, 008960-21, 008961-21, 008963-21, 008964-21, 008965-21, 008966-21, 008967-21, 008968-21, 010129-21, 010135-21, 010717-21, 011605-21, 012017-21	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 Peterborough ON K9J 6X6

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

The Willows Estate Nursing Home
13837 Yonge Street Aurora ON L4G 3G8

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

MOSES NEELAM (762), JACK SHI (760)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 3-6, 9-10, 2021

The following intakes were inspected upon during this Critical Incident System (CIS) and Follow up Inspection:
Log regarding follow-up to CO#006 from inspection #2021_715672_0016 related to meal service
Log regarding follow-up to CO#005 from inspection #2021_715672_0016 related to positioning of residents during meals
Log regarding follow-up to CO#001 from inspection #2021_715672_0016 related to assistance during meal times
Log regarding follow-up to CO#004 from inspection #2021_715672_0016 related to labeling of personal items
Log regarding follow-up to CO#003 from inspection #2021_715672_0016 related to infection control
Log regarding follow-up to CO#002 from inspection #2021_715672_0017 related to training and orientation
Log regarding follow-up to CO#001 from inspection #2021_715672_0017 related to medication storage
Log regarding follow-up to CO#001 from inspection #2021_715672_0018 related to reporting to the director
Log regarding follow-up to CO#002 from inspection #2021_715672_0018 related to calling substitute decision makers (SDM) after an incident
Log regarding follow-up to CO#003 from inspection #2021_715672_0018 related to restraints
Log / CIS related to abuse/neglect of a resident
Log / CIS related to abuse/neglect of a resident
Log / CIS related to an incident that lead to an injury
Log / CIS related to abuse of a resident
Log / CIS related to neglect of a resident

During the course of the inspection, the inspector(s) spoke with Residents, Chief Officer of Operations, the Administrator, Director of Operations, Director of Care (DOC), Maintenance worker, Complainants, BSO & IPAC Lead, Care Aide, Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs)

During the course of the inspection, the inspector toured the home, observed

infection prevention and control practices at the home, and reviewed clinical records.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Training and Orientation

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 112.	CO #003	2021_715672_0018	760

O.Reg 79/10 s. 129. (1)	CO #001	2021_715672_0017	762
O.Reg 79/10 s. 229. (4)	CO #003	2021_715672_0016	760
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2021_715672_0018	762
O.Reg 79/10 s. 37. (1)	CO #004	2021_715672_0016	762
O.Reg 79/10 s. 71. (6)	CO #006	2021_715672_0016	760
O.Reg 79/10 s. 73. (1)	CO #005	2021_715672_0016	760
O.Reg 79/10 s. 73. (2)	CO #001	2021_715672_0016	760
LTCHA, 2007 S.O. 2007, c.8 s. 76. (2)	CO #002	2021_715672_0017	762
O.Reg 79/10 s. 97. (1)	CO #002	2021_715672_0018	762

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. (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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #010 is reassessed, and the plan of care reviewed and revised when, the resident no longer needed a specific intervention for care.

A CIS report was submitted to the Director regarding an allegation of neglect for care by the SDM of the resident, due to the presence of infection. A review of the resident care plan indicated that the resident required a specific intervention for care. In separate interviews, PSW #117 and #118 indicated that they hadn't used the intervention for the resident in a while because the resident would be at risk for an incident. Furthermore, RPN #116 indicated that the intervention was changed at a later date, however, the resident had not needed this intervention for months, and that they believe the intervention was stopped "long time ago". This was additionally confirmed by RN #119. PSW #117 and #118, indicated the resident is currently using a different intervention for care, however, the resident would refuse or not comply with this intervention, hereby making care difficult. As a result, the resident was at risk for developing an infection due to the inconsistent provision of care.

Sources: Care plan; CIS report; Interviews with PSW #117, #118, RPN #116 and RN #119 [s. 6. (10) (b)]

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 resident is reassessed, and the plan of care reviewed and revised when, the resident's care needs change or care set out in the plan is no longer necessary, 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the names of all staff members were reported to the Director regarding an allegation of abuse with resident #004.

A CIS report was submitted by the home related to an allegation of abuse with the resident. A review of the CIS report indicated that DOC #103 was the sole staff who had responded to the incident. An interview with PSW #114 indicated that they had initially responded with a care aide and RN #104, when the resident initially made the allegation of abuse. The DOC confirmed that the names of all the staff who were involved in an alleged incident of resident abuse should be reported to the Director.

Sources: Review of CIS report; Interview with DOC #103, PSW #114 and other staff. [s. 107. (4) 2. ii.]

Issued on this 27th day of August, 2021

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

Original report signed by the inspector.