Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2018	2018_712665_0002	021306-17, 021597-17, 024222-17, 024242-17	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

JOY IERACI (665)

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 28, 2018, March 1, 2, 5, 6, 7, 8, 13, 14 and 15, 2018. Off site interviews were conducted on March 16, 18 and 28, 2018.

The following intakes were completed in this complaint inspection:
Log # 024222-17 related to responsive behaviours and resident to resident abuse.
Log #021306-17 related to resident to resident abuse.
Two CIS reports related to the same issue were inspected concurrently:
Log #021597-17, CIS #2945-000029-17.
Log #024242-17, CIS #2945-000034-17.

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 6(7), s. 6(11b) and s.19 were identified in this inspection and has been issued in CIS Inspection Report #2018_712665_0003, dated July 16, 2018, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Resident Relations Coordinator (RRC), , Registered Practical Nurses (RPNs), Registered Nurses (RNs), Behavioural Support Ontario (BSO) RPN, Registered Practical Nurses (RPNs), Resident Programs Team Member, Personal Support Workers (PSWs), residents and complainants.

The inspector also conducted medication administration observations, staff and resident interactions, provision of care observations, reviewed clinical health records, reviewed meeting minutes, training records, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	Legendé 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint, through the ACTIONline on an identified date in 2017. The complainant alleged that resident #001 was abused on an identified date in 2017, by another resident, who entered resident #001's room, sustaining an injury to an identified area of resident #001's body. The home submitted a Critical Incident System (CIS) report #2945-000029-17 of the incident five days after the alleged abuse on resident #001. The CIS report was submitted as a mandatory report for resident to resident abuse.

Interview with the complainant on an identified date in 2018, confirmed they sent an email to the previous Director of Care (DOC) on an identified date in 2017, regarding their allegation that resident #001 was assaulted by resident #002 the day before. The complainant indicated that the family requested a meeting with the home to discuss the safety of resident #001. Four days after the email was sent to the DOC, the complainant

and the substitute decision maker (SDM) met with the management of the home.

Review of the home's investigation notes indicated the previous DOC received the complainant's email concern at 2311 hours (hrs) on an identified date in 2017. The home's complaint record of the concern indicated the previous DOC sent an email response the following day, to confirm a care conference on an identified date, with the complainant and SDM.

Interview with the Executive Director (ED) indicated it is the home's policy for any allegation, suspected or actual abuse be reported to the MOHLTC immediately. The ED confirmed the home received an email from the complainant alleging abuse by resident #002 towards resident #001. The ED indicated the home considered the email a written complaint with an allegation of abuse when the email was reviewed the following business day . When the ED was asked why the home submitted the CIS report three days after the email was received by the previous DOC, the ED indicated that the previous DOC initiated an investigation immediately upon receiving the email, and was informed that abuse did not occur as the reason for not reporting the allegation of abuse from the complainant immediately to the MOHLTC. The allegation of abuse from the complainant was submitted to the MOHLTC when the home met with the complainant and the SDM, requesting the home to re-open the investigation. [s. 24. (1)]

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 abuse of a resident by anyone that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint, through the ACTIONline on an identified date in 2017. The complainant alleged that resident #001 was abused on an identified date in 2017, by another resident, who entered resident #001's room, sustaining an injury to an identified area of resident #001's body. The home submitted a Critical Incident System (CIS) report #2945-000029-17 of the incident five days after the alleged abuse on resident #001. The CIS report was submitted as a mandatory report for resident to resident abuse.

A review of resident #001's plan of care under the behaviour focus indicated an intervention for hourly safety checks. Review of the point of care (POC) documentation by the personal support workers (PSWs) indicated on the day of the critical incident (CI), the hourly safety checks were not documented on seven identified times. Review of the staffing schedules on the day of the CI, indicated PSWs #116 and #117 worked on the identified times.

Interviews with PSWs #116 and #117 indicated it is expected for safety checks to be documented in POC to ensure that the care was provided to the resident.The PSWs indicated they provided the hourly safety checks for resident #001, but missed to document the checks in POC.

Interview with the Associate Director of Care (ADOC) indicated it is the home's expectation for PSWs to document completion of tasks in POC to indicate the plan of care for residents were followed. The ADOC reviewed the POC documentation on the day of the CI, and confirmed the missing hourly safety check documentation by PSWs #116 and #117. [s. 6. (9) 1.]

Issued on this 18th day of July, 2018

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

Original report signed by the inspector.