Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 31, 2019	2019_659189_0015	008547-19, 013189-19, 015806-19, 018630-19, 019258-19	Critical Incident System

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

NICOLE RANGER (189), NITAL SHETH (500)

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): October 22, 23, 24, 25, 28, 2019.

During the course of the inspection, the following Critical Incident System (CIS) intake logs were inspected:
Log #008547-19, #019258-19, #013189-19, #018630-19 related to Falls Prevention
Log #015806-19 related to Hospitalization and Change in Condition

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Nurse Manager (NM), Physiotherapist (PT), registered nurse (RN), registered practical nurse (RPN), personal support workers (PSW), and residents.

During the course of the inspection, the inspector conducted observations of resident to resident interactions, staff to resident interactions and provision of care, review of resident and home records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **1 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long Term Care (MLTC) related to an incident that causes an injury to resident #003 for which the resident is taken to hospital and resulted in a significant change in the resident's health status.

According to the CIS report, resident #003 had a fall incident on an identified date. The resident was sent to the hospital on the identified date due to change in condition. The resident returned from the hospital a few days later.

A review of resident #003's written care plan indicate that the resident is high risk for falls and requires an identified fall prevention intervention. The staff is to help the resident when the fall prevention intervention is engaged.

A review of the resident's progress notes indicate that the resident had multiple falls within a five month period. On two occasions, it was identified that the fall prevention intervention was not engaged.The Physiotherapist (PT) assessed the resident after one incident of the resident's fall and noted although the fall prevention intervention were in place for the resident, it did not work at the time of the fall.

A review of the home's fall prevention committee meeting notes indicate that fall prevention intervention are found to be disengaged, and that all Personal Support Workers (PSW) are to ensure that residents' fall prevention interventions are engaged at the beginning of the shift and to continue to monitor throughout the shift.

A review of the home's policy# VII-G-30.10, entitled, "Fall Prevention and Management", revised April 2019, indicated that the PSW/resident care aide will utilize fall prevention interventions identified on the resident's plan of care for fall prevention and management.

During interview with PSW #101, PSW #110, RPN #104, Nurse Manager #106, ADOC #111, and the Physiotherapist, they indicated that resident #003 requires an identified fall prevention intervention. By failing to ensure that the identified fall prevention intervention was engaged on two incidents when resident #003 sustained falls, the home failed to ensure that the care set out in the plan of care related to falls prevention was provided. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 12th day of November, 2019

[redacted]

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

Original report signed by the inspector.