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
Jan 19, 2021	2020_780699_0019	011114-20, 016314-20, 019088-20, 019089-20, 019090-20, 019091-20	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

PRAVEENA SITTAMPALAM (699), IVY LAM (646)

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): November 23-26, 30, and December 1-4, 7-8, 2020.

The following complaint intakes were inspected:

-Log 011114-20 related to improper assessment of a resident;
-log 016314-20 related to abuse and neglect of a resident; and
-log 014908-20, 010131-20 related to falls and alleged neglect.

The following Compliance order follow up intakes were inspected:

-Log 019088-20 related to Compliance order #005 regarding availability of supplies in the home;
-log 019089-20 related to compliance order #006 regarding certificate of registration of registered staff with the College of Nurses;
-log 019090-20 related to compliance order #001 regarding having a registered nurse in the home; and
-log 019091-20 related to compliance order #007 regarding medication incidents.

During the course of the inspection, the inspector(s) spoke with Consultant Director of Care (CDOC), Director of Care (DOC), Associate Executive Director (AED), Associate Director of Care (ADOC), registered practical nurse (RPN), and personal support worker (PSW).

During the course of the inspection, the inspectors conducted observations of staff and resident interactions and provision of care, reviewed resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Hospitalization and Change in Condition
Medication
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 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. 135. (1)	CO #007	2020_780699_0014	699
O.Reg 79/10 s. 44.	CO #005	2020_780699_0014	699
O.Reg 79/10 s. 46.	CO #006	2020_780699_0014	699
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2020_780699_0014	699

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's plan of care was being revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care.

The Ministry of Long-term Care (MLTC) received a complaint regarding care not being provided appropriately to the resident. The inspector reviewed a picture that was taken of the resident's toenails, which were not trimmed. Staff stated that foot care is provided to residents on their shower days. Staff indicated that the resident exhibited responsive behaviours which made it difficult to provide the resident with foot care and additionally, the resident's toenails were difficult to trim. A review of the care plan did not indicate the resident exhibited any resistance to foot care or that the resident's toenails were difficult to trim. No interventions were in place related to the resident's behaviour when providing foot care. In an interview with the consultant DOC #100, they stated it was the expectation that the resident's plan of care be reassessed if the interventions were not effective with different approaches, such as involving the POA or continued re-approach on different days or shifts.

Sources: Picture taken of the resident's toenails, interviews with RPN #107 and Consultant DOC #100.

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 when a resident is reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that one resident received preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

A foot care nurse came to trim the resident's toenails, however indicated the resident required additional maintenance visits. Staff confirmed that the resident exhibited responsive behaviour, and often did not allow staff to perform nail care. The resident required additional visits from the foot care nurse, which had not been provided since the foot care nurse last visit. Consultant DOC #100 confirmed, based on the images, that the resident was not provided appropriate foot care.

Sources: Picture taken of the resident's toenails, interviews with RPN #107 and Consultant DOC #100.

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 each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

**s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).**

**s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).**

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, the symptoms of infection for a resident were recorded, and that immediate action was taken as required.

The following is further evidence to support Compliance Order #001 issued on October 14, 2020, during inspection 2020_780699_0014 with compliance due date of November 13, 2020.

A resident began to show symptoms of infection on an identified date. The resident was diagnosed with an infection three days later.

The resident's substitute decision-maker (SDM) requested the resident to be sent to hospital, but was not sent to hospital until nine days later. Symptoms were not monitored on each shift during this period. Vital signs other than temperature were not documented after a specified date. Staff reported the resident's symptoms worsened and no action was identified in response to the symptoms.

ADOC #103 and the corporate partner indicated registered staff should have monitored the resident's vitals, reported the resident condition to the physician and sent the resident to hospital when requested by the SDM.

Sources: Resident’s progress notes, eMAR, vitals (temperature, respiration, oxygen saturation, blood pressure, and pulse) records, Daily Active Screening records, observation of the resident, resident's hospital discharge records, interviews with RPNs #107 and #108, ADOC #103, the Corporate Consultant, and other staff.

Issued on this 1st day of February, 2021

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

Original report signed by the inspector.