Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
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Original Public Report

Report Issue Date: March 5, 2024
Inspection Number: 2024-1429-0001
Inspection Type: Complaint Critical Incident
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Villa Santa Maria Community, Woodbridge

Lead Inspector	**Inspector Digital Signature**
Chinonye Nwankpa (000715)	
Additional Inspector(s) Britney Bartley (732787) Dorothy Afriyie (000709)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 26, 29-31, 2024 and February 1, 2, 5-7, 2024

The following intakes were completed in this Critical Incident (CI) Inspection:

- Intake: #00101093 – CI #2945-000080-23; Intake: #00101585 – CI #2945-000082-23 – Injury of unknown cause;
- Intake: #00102007 – CI #2945-000087-23 – Alleged staff to resident neglect
- Intake: #00102280 – CI #2945-000089-23; Intake: #00105684 -CI #2945-000001-24; Intake: #00105815 – CI #2945-000003-24 - Outbreak

- Intake: #00102518 – CI #2945-000090-23; Intake: #00102609 – CI #2945-000091-23; Intake: #00106160 – CI #2945-000004-24 – Falls prevention and management
- Intake: #00103492 -CI# 2945-000095-23 – Alleged staff to resident

The following intakes were completed in this Complaint Inspection:
- Intake: #00103529 – Alleged staff to resident neglect
- Intake: #00103911 and Intake: #00105983 - Drug administration, allegation of neglect, and care and services
- Intake: #00104533 – Fall prevention and management; and injury of unknown cause
- Intake: #00106598 - Pest control, housekeeping, and care and services.

The following **Inspection Protocols** were used during this inspection:

Continence Care
Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that there was a written plan of care for a resident that set out their planned care.

Rationale and Summary
A resident's care plan did not include the planned care for their specific care needs.

A Personal Support Worker (PSW) and the Assistant Director of Care (ADOC) acknowledged the resident's care plan did not include the specific care needs.

When there was no planned care for the resident, it increased the risk of inconsistent and improper management of their specific care needs.

Sources: Resident's clinical records, PSW Documentation Survey report; interviews with the PSWs, and ADOC. [000715]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

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

Rationale and Summary
(i) A resident sustained an injury of unknown cause.

The resident's plan of care indicated that they required a specific device as part of their fall prevention interventions.

A PSW confirmed that the resident did not have the device applied when the injury was discovered.

A PSW, Registered Practical Nurse (RPN), and the Director of Care (DOC) acknowledged that the resident's care plan was not followed.

Failure to apply the device as specified in their plan of care placed the resident at increased risk of injury.

Sources: Resident's plan of care, the home's investigation notes; interviews with the PSW, RPN, and DOC. [000709]

(ii) A resident's plan of care indicated that they required assistance for their care.

A PSW failed to provide assistance with the care of the resident.

The PSW confirmed that they did not provide assistance with the resident's care as specified in their care plan. A RPN and the DOC acknowledged that the plan of care was not followed.

The licensee has failed to provide assistance to the resident during their care which placed them at risk.

Sources: Resident's record review, the home's investigation notes; interviews with the PSW, RPN, and DOC. [000709]

WRITTEN NOTIFICATION: Directives by Minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applied to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, the licensee was required to ensure that the masking requirements set out in the COVID-19 guidance document for long-term care homes in Ontario, effective November 07, 2023, were complied with.

Rationale and Summary
The COVID-19 guidance document for long-term care homes in Ontario, effective November 07, 2023, directed the homes that masks were required to be worn indoors in all resident areas by all staff, students, volunteers, and support workers.

A PSW was observed seated with residents with their mask below their chin. The facility had been in respiratory and COVID-19 outbreaks at the time of the observation.

The PSW acknowledged that they should not have removed their mask in the presence of residents.

Failing to wear a mask while in close proximity to residents increased the risk

communicable disease transmission.

Sources: Observations; Minister's Directives: COVID-19 response measures for long-term care homes (August 30, 2022), COVID-19 guidance document for long-term care homes in Ontario (November 07, 2023); interviews with the PSW. [000715]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
A resident experienced a fall.

The home's Falls Prevention and Management policy noted that after a fall, the resident should not be moved before the completion of a specific assessment by the nurse. The policy further stated staff were to use the appropriate lifting procedure to mobilize the resident post-fall.

The home's investigation notes showed that a Registered Nurse (RN) did not complete a specific post-fall assessment before the resident was transferred. As a result, a PSW used an unsafe technique to transfer the resident.

The ADOC acknowledged a full assessment was not completed as per the home's policy and that staff failed to use a safe transfer technique.

There was risk of further injury when staff used an unsafe technique to transfer the resident after the fall incident.

Sources: Resident's clinical records, Falls Prevention & Management, VII-G-30.10, last revised 04/2022; interviews with the PSWs, RPN, RN, and the ADOC. [000715]

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

The licensee has failed to ensure that procedures were developed and implemented for the cleaning of the home, including the common areas and floors.

Rationale and Summary
Observations made by Inspector revealed there was litter and food crumbs on the floor of specified areas in the Home. A Housekeeper reported seeing ants in these areas.

A RPN relayed that the specified area was not on a cleaning schedule. The Environmental Supervisor (EVS) verbalized that there had been complaints about the cleanliness of the specified area, as well as ant sightings. The expectation was for the housekeeping staff to clean the floors, move tables and chairs to clean properly, clean corners and behind the doors. The EVS acknowledged the specified

areas were not cleaned on the date of observation.

Failing to clean the floors increased the risk of pest control issues.

Sources: Observations; interviews with the Housekeeper, RPN, and EVS. [000715]

WRITTEN NOTIFICATION: Administration of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident experienced a specific medical issue. The resident's chart contained medical directives to be initiated when the resident experienced the specific medical issue.

The RPNs who worked on the unit during this period acknowledged they did not initiate the medical directive.

Failing to administer the medication as ordered to the resident increased the risk of worsening their condition.

Sources: Resident’s clinical records; interviews with the RPNs. [000715]