Ontario

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

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

Toronto District
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Original Public Report

Report Issue Date: April 15, 2024	
Inspection Number: 2024-1429-0002	
Inspection Type: Complaint Follow up	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Villa Santa Maria Community, Woodbridge	
Lead Inspector Parimah Oormazdi (741672)	Inspector Digital Signature Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2024.04.18 12:45:25 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 25-28, 2024 and April 3, 2024

The following intakes were completed in this complaint inspection:

- Intake: #00111287 was related to concerns with plan of care, neglect, responsive behaviours, communication methods, foot care.

The following Compliance Order (CO) Follow up intakes were inspected:

- Intake: #00104720 - CO #001 under inspection #2023-1429-0009, O. Reg. 246/22 - s. 102 (2) (b); Infection Prevention and Control (IPAC), Compliance Due Date (CDD): February 9, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1429-0009 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Parimah Oormazdi (741672)

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
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 (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.

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

Rationale and Summary
A resident's care plan indicated that they required to be transferred to the washroom by utilizing a specific transferring device, however the home's

investigation notes revealed that a Personal Support Worker (PSW) made them walk with utilizing another transferring device.

The PSW confirmed that they walked the resident utilizing a transferring device that was different than the one indicated in the resident's care plan. The Physiotherapist indicated that the resident had a medical diagnosis with which being walked was contraindicated, even with a transferring device and staff assistance. An Associate Director of Care (ADOC) acknowledged that the resident was not transferred to the washroom by utilizing the transferring device that was specified in their care plan.

Failure to ensure that the resident was provided with care as set out in their care plan, placed the resident at risk of injury.

Sources: The resident's care plan, home's investigation notes, and interviews with a PSW, a physiotherapist and an ADOC.

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2) The licensee has failed to ensure that the nutrition care set out in a resident's plan of care was provided to them.

Rationale and Summary
It was observed that a package of regular texture fruit was provided as a labeled snack to the resident, when they were supposed to receive assorted fruit cup as per the label. Their nutrition care plan indicated that they should have received modified texture fruits.

A PSW indicated that they distributed the morning snacks as per the label attached to that snack package provided to the resident, they did not correspond with the resident's diet. The Dietary manager acknowledged that the labeled snack was not provided as per the resident's nutrition care plan. They indicated that the kitchen

staff should have prepared the snack as specified in the resident's care plan.

Failure to follow the resident's nutrition care plan, put the resident at risk of choking.

Sources: Observation of the resident, the resident's care plan, interviews with a PSW and the dietary manager.

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WRITTEN NOTIFICATION: FOOT CARE AND NAIL CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 39 (1)
Foot care and nail care
s. 39 (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.

The licensee has failed to ensure that a resident received preventive and basic foot care services, including the cutting of toenails.

Rationale and Summary
A complaint was submitted to the Director related to a resident's toenails being overgrown, and that the resident did not receive foot care by the home for several months. One of the resident's toenails was found broken which caused an injury. A review of skin and wound assessment on a specific date revealed that the resident's toenails were extended past the end of each toe. The last two quarterly Resident Assessment Instrument-Minimum Data Sets (RAI-MDS) revealed that the resident's toenails were not trimmed in past one hundred and eighty days.

The home's foot care policy directed PSWs to provide routine foot care including trimming, cleaning and filing of nails during residents' bath time, except for those

residents diagnosed with a disease process that impairs or compromises a resident's circulation to their feet, such as diabetes. The policy also indicated that the nurse must be informed of any changes in resident's feet.

Two PSWs acknowledged that they did not trim the resident's toenails on their shower days and did not inform the registered staff of this issue. Two Registered Practical Nurses (RPNs) indicated the staff did not report to them that the resident's toenails were not being trimmed. In addition, they indicated that the resident did not have any health conditions that precluded PSWs from providing nail care. A Resident Assessment Instrument (RAI) coordinator indicated that they did not identify any documentation related to the resident's toenails being trimmed. The Director of Care (DOC) confirmed that the PSWs should have cut the resident's toenails on a regular basis

Failure to cut the resident's toenails put the resident at risk of injury.

Sources: Review of the resident's clinical records, Foot Care Protocols and Referrals, VIII-C-10.00, last revised on December 2023; interviews with two PSWs, RPNs, a RAI coordinator and the DOC.

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