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

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Original Public Report

Report Issue Date: October 31, 2024

Inspection Number: 2024-1429-0004

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 24-27, 2024 and October 1-4, 7-11, 15-18, 2024
The inspection occurred offsite on the following date(s): October 25, 28, 29, 2024

The following intakes were inspected in this Critical Incident System (CIS) inspection:

- Intake: #00114687 [CI: 2945-000019-24] - related to an injury of unknown cause of a resident
- Intake: #00115801 [CI: 2945-000022-24] - related to potential resident-to-resident physical abuse
- Intake: #00116334 [CI: 2945-000024-24] - related to alleged neglect and oral care of a resident
- Intake: #00120527 [CI: 2945-000036-24] - related to a fall of a resident resulting in an injury
- Intake: #00128522 [CI: 2945-000056-24] - related to a disease outbreak

The following intakes were inspected in this Complaint inspection:

- Intake: #00123192 - related to alleged neglect, improper care, continence care, plan of care, medication management, housekeeping, safe and secure home, palliative care, recreational activities, and a fall of a resident
- Intake: #00126705 - related to alleged neglect, medication management, improper care, and plan of care resulting in hospitalization
- Intake: #00127532 - related to injury of unknown cause, responsive behaviours, and safe and secure home

The following intakes were completed in this CIS inspection:

- Intakes: #00110255 [CI: 2945-000007-24], #00115586 [CI: 2945-000020-24], #00120917 [CI: 2945-000037-24], #00122951 [CI: 2945-000041-24], #00125721 [CI: 2945-000049-24], and #00128025 [CI: 2945-000055-24] - related to resident falls resulting in an injury
- Intake: #00115567 [CI: 2945-000021-24] and #00125710 [CI: 2945-000050-24] - related to disease outbreaks

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
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 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's Substitute Decision-Maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A resident was ordered a medication. There was no documented record found in the resident's clinical records indicating the home informed the SDM of the new medication order.

Two Registered Practical Nurses (RPN) and an Associate Director of Care (ADOC) could not confirm if the home notified the SDM of the new medication order.

The ADOC indicated it is the nurses responsibility to inform the resident's SDM of new medication orders.

Failure to involve the resident's SDM in the resident's plan of care related to a change in treatment, resulted in the SDM not being notified in a timely manner.

Sources: A resident's clinical records; interviews with two RPNs, and an ADOC.

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 falls prevention interventions were provided to a resident as specified in their plan of care.

Rationale and Summary
A resident was at high risk of falls. Staff was to ensure the resident wore a falls prevention intervention at all times to minimize injury from a fall. During an observation, the resident was not wearing this falls prevention intervention.

A Personal Support Worker (PSW) acknowledged that the resident was not wearing the falls prevention intervention during the above-mentioned observation. The PSW acknowledged there was a risk to the resident when the the falls prevention intervention was not applied.

An ADOC and a Director of Care (DOC) confirmed the resident should wear the falls prevention intervention at all times.

Failure to provide the falls prevention intervention to the resident as specified in the plan of care posed a risk of harm.

Sources: An Observation; Care Plan; Interviews with a DOC, an ADOC, and a PSW.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
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.

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

Rationale and Summary
A review of a resident's electronic record demonstrated there was no documentation for an assessment that was done by an RPN.

The RPN was informed by the resident's SDM that the resident had a change in condition. The RPN indicated they assessed the resident and indicated there was no concern found from their assessment. The RPN acknowledged their assessment was not documented in the resident's record.

An ADOC indicated the RPN should have documented their assessment.

Failure of the home not documenting the provision of care for the resident put the resident at risk of other care providers not having an accurate account of the resident's condition.

Sources: A resident's clinical records; interviews with an RPN and an ADOC.

WRITTEN NOTIFICATION: Policies and records

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)

Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to comply with the home's Head Injury Routine (HIR) policy when a resident had a potential head injury.

Rationale and Summary
The home's HIR policy required staff to initiate the HIR on any resident who has sustained or was suspected of sustaining a head injury.

A resident was found with evidence of a potential head injury. Two days later, additional evidence of a potential head injury was identified by staff. The resident's record showed HIR was initiated one day following the discovery of the initial injury.

An RPN confirmed that they had initiated the HIR for the resident due to the potential head injury. A DOC acknowledged that staff were expected to initiate HIR on the day the potential injury was first identified on the head.

Failure to comply with the home's HIR policy and procedures could lead to staff's lack of awareness of changes in the resident's condition related to their injuries.

Sources: A resident's clinical records; Home's HIR Policy; Interviews with an RPN and a DOC.

WRITTEN NOTIFICATION: Altercations and other interactions

between residents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that an intervention for a resident to minimize the risk of altercation and potentially harmful interaction with another resident was implemented.

Rationale and Summary
Two residents had an altercation where staff had intervened and separated them. As a result of this altercation, one resident's plan of care was revised to ensure that they were separated from the other resident when they are in a specific location in the Resident Home Area (RHA) to avoid altercation.

During an observation, the two residents were sitting beside each other in the above-mentioned location in the RHA. An RPN verified that both residents were sitting next to each other. However, they were unaware of the intervention in place in the resident's plan of care. A DOC confirmed that staff were expected to follow the interventions in the resident's plan of care and therefore the two residents should not have been sitting together.

Failure to ensure that staff implemented the intervention in the resident's plan of care could lead to a risk of an altercation and potentially harmful interaction with the

other resident.

Sources: A resident's clinical records; An observation; Interviews with an RPN and a DOC.

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 a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident's medications scheduled for 1200 hours (hrs) were found in a cup on their bedside table at 1350 hrs. As per the resident's Electronic Medication Administration Record (EMAR) the medications were signed and administered at 1145 hrs by an RPN. The RPN indicated the resident refused the medication and told them to leave it on the table.

A DOC acknowledged the RPN was to ensure the resident takes their medication, not leave it in the resident's room and not to document the administration until administered to the resident.

There was potential risk to the resident's health, safety and well-being when not

being provided the medication as prescribed.

Sources: A resident's clinical health records; an observation; interviews with an RPN and a DOC.