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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Public Report

Report Issue Date: March 11, 2025

Inspection Number: 2025-1429-0003

Inspection Type:
Other
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): February 24 -28, 2025 and March 3 -7, 10, and 11, 2025

The following complaint intakes were inspected:
-Intake #00137746, Intake #00139117 – Related to an injury of unknown cause.

The following Critical Incident (CI) intakes were inspected:
-Intake #00135946 / CI #2945-000070-24– Related to a fall resulting in an injury.
-Intake #00136331 / CI #2945-000001-25, Intake #00139360 / CI #2945-000005-25, Intake #00140078 / CI #2945-000007-25 – Related to a disease outbreak.
-Intake #00137751 / CI #2945-000002-25, Intake #00138904 / CI #2945-000004-25 – Related to an injury of unknown cause.
-Intake #00139619 – Related to an emergency planning annual attestation.

The following intakes were completed in this inspection:
-Intake #00139814 / CI #2945-000006-25 – Related to a fall resulting in an injury.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: SAFE AND SECURE HOME

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the hallway was a safe environment for a resident.

A resident was ambulating with their assistive device in the hallway when the device hit a yellow wet floor sign, causing the resident to fall and sustain an injury. The Environmental Service Manager (ESM) and the Assistant Director of Care (ADOC) acknowledged that the yellow wet floor signs should not have been left unattended to ensure the safety of the resident.

Sources: Review of the resident's clinical records and, CIS #2945-000070-24, interviews with the ESM, ADOC and other staff.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that staff and others involved in different aspects of care collaborated effectively to complete a resident's diagnostic test.

The physician ordered a diagnostic test for the resident, however, there was a delay in completing the test. The Registered Practical Nurse (RPN), ADOC, and the Director of Care (DOC) were unaware of the reason for the delay and acknowledged that the nursing staff failed to collaborate in the resident's assessment.

Sources: Review of the resident's clinical records, interviews with the RPN, ADOC, and the DOC.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff collaborated with each other in the implementation of the plan of care for a resident related to pain medication.

The RPN stated that the Personal Support Worker (PSW) did not report the resident's pain to them, therefore they did not administer their pain medication.

Sources: Review of the resident's Electronic Medication Records (eMAR), and interviews with the PSW and the RPN.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 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 the care set out in a resident's plan of care related to fall prevention interventions was provided to them.

The resident was left unsupervised, awake, and sitting in their assistive device in their room for a period of time. The PSW stated that they did not place the resident in a supervised area for safety, as indicated in their plan of care.

Sources: The resident's plan of care, home's camera video footage, and interviews with the PSWs and the ADOC.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 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 RPN documented a resident's assessment.

The PSWs reported a change in the resident's condition to the RPN. The RPN stated that they completed the resident's vital signs assessment but did not document it in Point Click Care (PCC).

Sources: Review of the resident's clinical records, and interviews with the PSWs, RPN, and the DOC.

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that the pain management program to identify and manage pain was implemented for a resident.

In accordance with O. Reg 246/22, 11 (1) (b), the licensee is required to ensure a pain management program to identify and manage pain is implemented and is complied with.

Specifically, the home did not comply with their policy VII-G-30.30 “Pain & Symptom Management” last revised 10/2024.

The PSWs stated that they did not document the resident's pain electronically in Point of Care (POC) as per the home's policy.

Sources: Review of the resident's progress notes, policy VII-G-30.30 "Pain & Symptom Management" last revised 10/2024, and interviews with the PSWs.

WRITTEN NOTIFICATION: Pain management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure that a resident was monitored for their response to, and the effectiveness of, their pain management strategies.

The RPN stated that they did not reassess the resident on two occasions after administering their pain medication to monitor their response and the effectiveness of the pain medication.

Sources: Review of the resident's clinical records, and interview with the RPN.

WRITTEN NOTIFICATION: VISITOR POLICY

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 267 (1) (a)
Visitor policy

s. 267 (1) Every licensee of a long-term care home shall establish and implement a written visitor policy which at a minimum,
(a) includes the process for visitor access during non-outbreak situations and during an outbreak of a communicable disease, an outbreak of a disease of public health significance, an epidemic, a pandemic or another emergency;

The licensee has failed to ensure that the visitor policy was implemented.

The home's visitor COVID -19 Protocol indicated that during a COVID-19 outbreak, visitors are required sign in using the Kiosk/Visitor Sign in sheet. During an outbreak, four visitors entered the building without signing into the kiosk. The home's staff did not redirect the visitors to sign in as required.

Sources: Observations, home's protocol titled “Visitor COVID-19 Protocol (ON)” IX-N-10.44 (a), dated April 2024, interviews with Infection Prevention and Control (IPAC) Lead and other staff.

WRITTEN NOTIFICATION: CMOH AND MOH

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that the Recommendation for Outbreak Prevention and Control in Institutions and Congregate Living Settings issued by the Ministry of Health was followed in the home. In accordance with these recommendations, the licensee was required to conduct weekly IPAC audits during

a COVID-19 outbreak.

When the home experienced a COVID-19 outbreak, the IPAC lead confirmed that one of the weekly IPAC audits was not completed during this period.

Sources: Recommendation for Outbreak Prevention and Control in Institutions and Congregate Living Settings effective February 2025, review of home's COVID-19 self assessment IPAC audits, interview with IPAC Lead.