Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 12, 25, 2016	2016_405189_0008	002255-15, 029002-15, 001490-16, 004804-16, 007067-16, 009689-16, 009913-16, 010546-16, 013051-16, 013231-16, 013809-16, 015138-16, 015144-16, 015329-16, 015715-16, 016382-16, 016408-16, 017073-16, 017089-16, 017529-16	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO 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

NICOLE RANGER (189), SARAN DANIEL-DODD (116), SIMAR KAUR (654), SLAVICA VUCKO (210), THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 2, 3, 6, 7, 8, 9,10, 13, 14, 15, 16, 17, 2016.

The following intakes were inspected concurrently during this inspection: Critical Incident (CI) intakes related to abuse: 007067-16, 009689-16, 015705-16, 014847-16, 014077-16, 013051-16, 011578-16, 001490-16, 000595-16, , 009835-16, 015138-16, 017089-16, 017073-16, 017529-16, 004804-16, 029002-15, related to responsive behaviours: 015715-16, 013231-16, 016408-16, 015144-16, related to skin and wound: 010546-16, 013809-16, related to nutrition and hydration: 016382-16, related to fall prevention and management: 002255-15, 009913-16, 015329-16.

During the course of the inspection, the inspector(s) spoke with Interim Executive Director (ED), previous Executive Director, Director of Care (DOC), Nurse Manager, Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Behaviour Support Nurse (BSO), Falls Prevention Lead, Food Service Supervisor (FSS), Food Service Manager (FSM), housekeeping aide, private caregiver, personal support workers (PSW), family members, residents.

During the course of the inspection, the inspector conducted a tour of the resident home areas, observed resident and staff interactions, reviewed clinical health records and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

8 WN(s)
4 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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	Legendé 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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

On an identified date, Critical Incident System (CIS) was submitted to the Director related to alleged resident to resident abuse. Staff #134 witnessed resident #026 inappropriately touching resident #022.

A review of the home's investigation indicated the home initiated and implemented 1:1 close monitoring of 30 minute intervals for resident #026. Review of the written plan of care in relation to inappropriate responsive behaviours of resident #026 directed the staff to provide hourly safety checks and 1:1 close monitoring.

Throughout the inspection, inspector #116 observed the provision of 1:1 close monitoring of resident #026. Interviews held with RPN #104, PSW #134, RPN #135 and the Acting Executive Director confirmed that resident #026 requires 1:1 close monitoring and the

plan of care does not set out clear directions in relation to the monitoring requirements for resident #026. [s. 6. (1) (c)]

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

On an identified date, CIS was submitted to the Director related to the sudden death of resident #020. A review of the home’s investigation revealed that the resident had abnormal blood work at 0130 hours on an identified date. PRN medication was not administered to the resident. At 0230 hours the resident had sustained a fall in his/her room without injury. Blood work was re-taken. The resident was transferred to hospital. Record review of the resident's progress notes indicated that the resident expired in hospital on an identified date, and cause of death was an identified diagnosis.

Record review of resident #020's care plan indicated: if the outcome of identified blood work is an identified abnormal result, call POA and MD, communicate the family request to MD.

Interview with RPN #106 revealed that on an identified date, the resident's blood work was elevated at 2400 hours. When tested again at 0130 hours it remained elevated. The RPN did not call the doctor. RPN #106 indicated that he/she was planning to administer a PRN dose of medication an hour later at 0230 hours.

Interview with ADOC #107 and interim ED #101 revealed that RPN #106 should have contacted the physician when he/she discovered that the outcome of identified blood work is an identified abnormal result as indicated in the care plan and confirmed the resident's plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

3. A review of Critical Incident System (CIS) indicated on an identified date, resident #007's dressing was not changed according to the Enterostomal (ET) Nurse's recommendation made on an identified date.

A review of resident #007's progress notes and ET nurse assessment on an identified date, revealed the resident had three areas of altered skin integrity to an identified area of the body. Orders was put into place to cleanse the identified area. The resident was assessed at high risk of altered skin integrity. The weekly skin assessment on an identified date, revealed three new areas of impaired skin integrity besides the previous ones .

Interview with RPN #116 confirmed that the dressing on resident # 007 was not changed on an identified date as specified in the plan. [s. 6. (7)]

4. On an identified date, CIS was submitted to the Director related to alleged staff to resident abuse of resident #010.

Review of the written plan of care for resident #010 revealed that the resident is incontinent and requires assistance with changes.

The resident reported to the inspector that on an identified date, he/she did not receive assistance from PSW #105 to change his/her incontinent product during the day shift when required. Resident #010 reported that he/she informed RPN #118 that he/she was not changed and RPN #118 then spoke with PSW #105 to assist the resident with the incontinent change. The resident reported that when PSW #105 came into the room, he/she spoke to the resident in a loud tone, asked the resident to stand up and hold onto the bed rail, which the resident reported he/she is not able to do without the use of the standing lift.

Interview with RPN #118, PSW #105 and Interim Executive Director confirmed that the resident did not receive assistance to change his/ her incontinent product in a timely manner, and that the continence care set out in the plan of care was not provided to resident #010. [s. 6. (7)]

5. On an identified date, CIS was submitted to the Director related to alleged staff to resident abuse of resident #010.

Review of the written plan of care for resident #010 revealed that the resident was on a specified therapeutic diet.

PSW #105 reported to the inspector that on an identified date, he/she was in the dining room during lunch when he/she observed the resident eating a sandwich. PSW #105 reported that he/she took half of the resident's sandwich away as he/she thought that the resident was prescribed a half portion diet. PSW #105 reported that he/she did not verify on the plan of care the resident's diet. Interview with resident #010 confirmed that PSW #105 had taken away his/her sandwich and he/she felt bad that the PSW had taken away his/her meal.

Interview with PSW #105 and Interim Executive Director confirmed that resident #010 was on a specified therapeutic diet and that the care set out in the plan of care was not provided to resident #010. [s. 6. (7)]

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

Record review of resident #020's progress notes indicated that on an identified date, on the evening shift the resident's blood work was abnormal and medication was administered at 2215 hours.

Interview with RPN #106 who worked the night shift on the identified date revealed that he/she was informed at shift report about resident #020's abnormal blood work and to monitor throughout the shift. RPN #106 tested the blood work at 2400 hours and it had not normalized. The RPN reported that he/she forgot to document this abnormal result.

The severity of the non-compliance is minimal harm or potential for actual harm.
The scope of the non-compliance is a pattern.
The home has previously been issued a Voluntary Plan of Correction under LTCHA, 2007,. c.8, s. 6 (7), on March 14, 2016, within report #2016_378116_005. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On an identified date, CIS was submitted to the Director related to alleged staff to resident abuse of resident #010.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilzation that are performed by anyone other than a resident.

Under O. Reg. 79/10, s. 5 for the purpose of the definition of "neglect" in subsection 5 of the Act, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The resident reported to the inspector that on an identified date, PSW #105 assisted him/her with a shower and used lukewarm water which made the resident feel cold. The resident also reported that on the same date, PSW #105 did not assist the resident with incontinent changes until the resident informed RPN #118 who then spoke with PSW #105 to assist the resident. When PSW #105 came into the room, he/she spoke to the resident in a loud tone of voice that made the resident feel nervous and scared.

The resident also reported that on an identified date, during the lunch service in the dining room, the resident was eating a sandwich for lunch when PSW #105 came and took half the sandwich away from the resident and told the resident he/she should not be eating the sandwich. The resident reported he/she felt bad that the PSW had taken the sandwich away from him/her.

Interview with Interim Executive Director, Previous Executive Director, and PSW #105 confirmed the concerns from the resident and that resident #010 was not protected from abuse and neglect. [s. 19. (1)]

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 residents protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.
2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

On an identified date at 1658 hours, CIS was submitted to the Director related to an allegation of staff to resident abuse. On an identified date, the evening nurse manager RN #136 received a complaint from resident #010 about the treatment and care he/she received from PSW #105 at 2000 hours. The resident alleged physical and verbal abuse and voiced being emotionally distraught by the PSW. The evening nurse manager did not immediately report the suspicion and the information upon which it is based to the Director and an investigation was not initiated until the following day. [s. 24. (1)]

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 a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

On an identified date, CIS was submitted to the Director related to alleged staff to resident abuse of resident #002.

On an identified date, the Food Service Supervisor (FSS) and the Dietary student was in an identified home area TV room at 1430 hours conducting a snack observation. The FSS and Dietary student observed PSW #152 feeding resident #002 in a fast manner and standing while feeding the resident.

Interview with the Interim Executive Director and the Food Service Manager (FSM) revealed that the home's procedure for feeding residents requires the PSW staff to be sitting at the same level as the resident when feeding.

Interview with PSW #152 confirmed that he/she was standing while feeding the resident and the PSW and Interim ED confirmed that PSW # 152 was not following the home's procedure for feeding the resident. [s. 73. (1) 10.]

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 nsure that the home has a dining and snack service that includes, at a minimum, the following elements: Proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

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

On an identified date, CIS was submitted to the Director related to the sudden death of resident #020.

Record review of resident #020's physician's order indicated for an identified abnormal blood work result give PRN medication as needed.

Record review of resident #020's progress notes indicated that resident #020's blood work was tested with an elevated reading on the evening shift on an identified date.

Interview with RPN #106 reported that on the identified date, at the beginning of the night shift, he/she received shift report about resident #020's abnormal blood work by the evening nurse, and proceeded to test the resident's blood work at 2400 hours. The reading was elevated. Further testing of the resident's blood work at 0130 hours was higher. By 0230 hours the resident sustained a fall in the room and was transferred to hospital for assessment.

Record review of the resident's Medication Administration Record (MAR) did not include any signatures for the identified date, for the administration of medication to resident #020 who had identified abnormal blood work result.

Interview with RPN #106 revealed that he/she did not administer the resident's PRN medication as prescribed .The RPN was waiting until 0230 hours to administer the medication to the resident, as he/she thought PRN meant administer every four hours; it was last administered at 2230 hours by the evening nurse on an identified date.

Interview with ADOC #107 and Interim ED #101 confirmed that RPN #106 did not administer the medication to resident #020 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

A review of the "Skin and Wound Care Management Protocol", dated April 2016, revealed an introductory section named "policy" with content "each resident will have a skin assessment and where indicated, a treatment plan for the maintenance of skin integrity and wound management. The care community will identify a nurse (or nurses), who has (have) enhanced knowledge and skills in skin and wound care as the Skin and Wound Care Coordinator/Resource Nurse (s). The inter-professional skin care team plays a significant role in skin and wound management, promotes open communication, and monitors the outcome of the program. Further, the roles of the director of care, the skin care coordinator/resource nurse, registered staff, PSAs, RD, occupational/Physiotherapist and OT/PT Aide/Restorative Care Coordinator are described. The role of the registered staff is for a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcer, skin tears or wounds to initiate weekly skin assessment, and if the wound is worsening or is not responding to treatment, to initiate an electronic ulcer referral form".

A review of the "Skin and Wound Care Management" policy and interview with the Skin Care Coordinator confirmed that the Skin and Wound Care Management Protocol does not include goals and objectives of the program. [s. 30. (1) 1.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. On an identified date, CIS was submitted to the Director related to alleged staff to resident abuse of resident #010.

Review of the written plan of care for resident #010 revealed that the resident requires mechanical lifts for transfers.

PSW #102 reported to the inspector that on an identified date, he/she was called to assist with the transfer for resident #010. PSW #102 reported he/she went into the room, placed the sling underneath the resident, guided the resident and maneuvered the control of the ceiling lift. PSW #102 reported that PSW #105 was in the room observing and did not actively participate in the transfer. Interview with PSW #105 confirmed that he/she was in the room and did not actively participate with the transfer.

During an interview with PSW #105 it was reported that on an identified date, he/she changed the resident at the bedside, while the resident was standing up holding onto the bed rail. PSW #105 reported that he/she assumed the resident was able to stand up and hold on as the resident reported that he/she is able to weight bear and did not require the standing lift. PSW #105 confirmed that he/she did not check the care plan to verify the correct method of transferring and toileting the resident as per the plan of care.

Interview with PSW #102, #105 and Interim Executive Director confirmed that resident #010 required a mechanical lift for transfers . The Executive Director confirmed that the PSW did not use safe transferring techniques when assisting resident #010. [s. 36.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

A review of resident #021's clinical record revealed on an identified date, the resident returned from hospital and he/she had an area of altered skin integrity. The weekly skin assessment on an identified date, revealed the altered area was large and deteriorated. The weekly skin assessment on an identified date, revealed there was odor from the altered area and the size was larger. A review of the physician's order revealed an order for a swab to be taken for culture and sensitivity (C&S) from the altered area. On an identified date, the Nurse Practitioner (NP) ordered vital signs to be checked three times a day for three days and prescribed medication .The progress notes revealed that on an identified date, the resident was transferred to hospital. The discharge report from hospital revealed that the resident had a massive area of altered skin integrity that required treatment.

A review of progress notes revealed on an identified date, the evening RPN #131 and the nurse manager checked the on-line lab results from the laboratory but they were not able to find them. Although the resident was identified with an area of altered skin integrity on an identified date and reassessed on two identified dates, the MD did not intervene until after, and the staff did not follow up on the physician's order and therefore immediate treatment did not occur and led to further deterioration of the altered area. [s. 50. (2) (b) (ii)]

Issued on this 26th day of October, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

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Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 12, 25, 2016
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	Woodbridge Vista Care Community 5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1

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Ministére de la Santé et des Soins de longue durée

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Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Kerri Judge

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To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the care set out in the plan of care is provided to residents as specified in the plan. The plan will include but not limited to the following:

1. A process to ensure that the care set out in the plan of care for each resident is provided to the resident as specified in the plan.

2. Develop and implement an auditing process that will identify when staff are not providing care as specified in the plans, so that corrective action can be taken.

3. A multidisciplinary process to ensure clear communication between front line staff, so that the care is provided to the residents as specified in the plans.

4. Educate the staff about ensuring the care plan is reviewed according to their policies prior to the provision of care.

Plan to be submitted via email to nicole.ranger@ontario.ca by October 28, 2016.

Grounds / Motifs :

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

Review of the written plan of care for resident #010 revealed that the resident was on a specified therapeutic diet.

PSW #105 reported to the inspector that on an identified date, he/she was in the

dining room during lunch when he/she observed the resident eating a sandwich. PSW #105 reported that he/she took half of the resident's sandwich away as he/she thought that the resident was prescribed a half portion diet. PSW #105 reported that he/she did not verify on the plan of care the resident's diet. Interview with resident #010 confirmed that PSW #105 had taken away his/her sandwich and he/she felt bad that the PSW had taken away his/her meal.

Interview with PSW #105 and Interim Executive Director confirmed that resident #010 was on a specified therapeutic diet and that the care set out in the plan of care was not provided to resident #010.
(189)

2. A review of Critical Incident System (CIS) indicated on an identified date, resident #007's dressing was not changed according to the Enterostomal (ET) Nurse's recommendation made on an identified date.

A review of resident #007's progress notes and ET nurse assessment on an identified date, revealed the resident had three areas of altered skin integrity to an identified area of the body. Orders was put into place to cleanse the identified area. The resident was assessed at high risk of altered skin integrity. The weekly skin assessment on an identified date, revealed three new areas of impaired skin integrity besides the previous ones .

Interview with RPN #116 confirmed that the dressing on resident # 007 was not changed on an identified date as specified in the plan
(210)

3. On an identified date, CIS was submitted to the Director related to the sudden death of resident #020. A review of the home's investigation revealed that the resident had abnormal blood work at 0130 hours on an identified date. PRN medication was not administered to the resident. At 0230 hours the resident had sustained a fall in his/her room without injury. Blood work was re-taken. The resident was transferred to hospital. Record review of the resident's progress notes indicated that the resident expired in hospital on an identified date, and cause of death was an identified diagnosis.

Record review of resident #020's care plan indicated: if the outcome of identified blood work is an identified abnormal result, call POA and MD, communicate the family request to MD.

Interview with RPN #106 revealed that on an identified date, the resident's blood work was elevated at 2400 hours. When tested again at 0130 hours it remained elevated. The RPN did not call the doctor. RPN #106 indicated that he/she was planning to administer a PRN dose of medication an hour later at 0230 hours.

Interview with ADOC #107 and interim ED #101 revealed that RPN #106 should have contacted the physician when he/she discovered that the outcome of identified blood work is an identified abnormal result as indicated in the care plan and confirmed the resident's plan of care was not provided to the resident as specified in the plan.

The severity of the non-compliance is minimal harm or potential for actual harm.
The scope of the non-compliance is a pattern.
The home has previously been issued a Voluntary Plan of Correction under LTCHA, 2007,. c.8, s. 6 (7), on March 14, 2016, within report #2016_378116_005. (596)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 09, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 12th day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NICOLE RANGER

Service Area Office /
Bureau régional de services : Toronto Service Area Office