Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 11, 2020	2020_780699_0015	013151-20, 013153-20, 013172-20	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

PRAVEENA SITTAMPALAM (699), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 2, 3, 5, 7, 8, 9, 2020.

The following intakes were completed during this inspection: Log #s: 013151-20, 013153-20, 013172-20 (all related to resident discharge).

During the course of the inspection, the inspector(s) spoke with the Executive Directors (EDs), the Director of Care (DOC), Interim Communication Lead (ICL), Resident and Family Experience Coordinators (RFECs), registered staff (RN/RPN) and substitute decision-makers.

During the course of the inspection, the inspector conducted interviews, record reviews and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 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	Légende 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 O.Reg 79/10, s. 146. When licensee shall discharge

Specifically failed to comply with the following:

s. 146. (6) A licensee shall not discharge a resident under clause (4) (c),
(a) if the resident is unable to return to the home because of an outbreak of disease in the home or an emergency in the home; or O. Reg. 79/10, s. 146 (6).
(b) if the resident or the resident's substitute decision-maker or other person acting on the resident's behalf has notified the Administrator that the resident intends to return to the home but the resident is unable to do so due to an emergency or natural disaster in the community or a short-term illness or injury of the resident that prevents the immediate return of the resident. O. Reg. 79/10, s. 146 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #015 and #016 were not discharged from the home if they were unable to return to the home because of an outbreak of disease in the home or an emergency in the home; or if their substitute decision-makers had notified the Administrator that they intended to return to the home.

The Ministry of Long-Term Care (MLTC) received a complaint related to resident #015's discharge from the long-term care home.

Record review of the Point Click Care (PCC) progress notes indicated, and family interview confirmed that resident #015 was granted a one-week vacation approval leave while the home was declared in an identified outbreak. The resident's substitute decision maker was permitted to pick up their prescribed medication package weekly until the resident was officially discharged from the home on a specified date.

During an interview, substitute decision-maker (SDM) #147 informed the inspector that they were concerned for the resident's safety and therefore thought it would be best to take them home during the outbreak. The SDM stated the following additional concerns: the previous Director of Care (DOC) had transferred to another home, there was nobody in the environmental service manager's role for months, a new executive director (ED) had just started, the resident's primary care physician took a leave of absence from the home, and there was a critical shortage of staff. Those factors together made the family very uneasy, therefore they contacted the home and requested that the resident be ready for pick up that same evening.

According to SDM #147, they were contacted by the home's Communication Lead #120 to have a discussion related to the resident's status because they were approaching the 21-day vacation leave of absence limit; followed by another email which outlined the reasons for the resident's discharge related to the ministry's Directive. The SDM acknowledged that the home provided one week's supply of the resident's medication and a medication prescription for three months supply of medication. At that time, the SDM was informed that they would be responsible for finding a community physician and pharmacy to support the resident's care going forward; and the name and contact information for the applicable Local Health Integration Network (LHIN) placement coordinator was also provided so that the family could arrange community support and readmission back into the home.

During an interview, RPN #119 acknowledged the information as written above; and verified they were called by SDM #147 and was informed that the family would be picking up the resident. The RPN stated they tried to contact the home's Resident and Family Experience Coordinators (RFEC), but they were busy; however, the RPN spoke briefly with ED #101 who provided approval for the resident to leave with the family. The RPN further verified that DOC #102 informed them that they should discharge the resident from the home's Admission/Discharge/Transfer (ADT) System after SDM #147 picked up the resident's medication package and the prescription for three months supply of medication. The RPN stated that they discharged resident #015 from the ADT system after a brief interaction with the SDM.

During an interview, ED #101 acknowledged that no explicit approval was given for the resident to leave with family, and the team had just finished a virtual town hall meeting when they spoke briefly with RPN #119. The ED acknowledged that the resident was discharged from the home during the COVID-19 outbreak.

2. Resident #016 was included in the inspection to expand the sample related to identified noncompliance.

Record review of the PCC progress notes indicated, and family interview confirmed that resident #016 left the home with SDM #148 on an identified date while the home was declared in outbreak. Prior to leaving the home, SDM #148 stated that they had informed RFEC #121 that they would return to the home the next day to pick up the resident's medication and other belongings. However, when they return to the home on a later date, the SDM was told they could not get the resident's medication from the home's pharmacy because the resident was no longer a resident of the home, they were officially

discharged on a specified date.

During the interview, SDM #148 stated that, they called the home and requested that the resident be ready to be picked up by the family. SDM #148 stated they arrived and waited outside in the vestibule area, and the staff brought the resident out with some of their belongings. At that time, RFEC #121 met and spoke to the SDM while wearing a face mask and face shield, provided a printed copy of the resident's electronic medication administration records (eMAR) which listed all their current medications, and a printed copy of the resident's written care plan prior to them leaving the home. When they returned to the home the following day to pick up the resident's medication as promised, they were provided with only one-day's dose of all the resident's medication and the contact number for Medical Pharmacies. The Pharmacist informed the SDM that because the resident was discharged from the home, they could no longer provide their medication; and the SDM should have a community pharmacist contact them so that they could give them the resident's prescribed medication.

During an interview, RFEC #121 acknowledged that they met and spoke with the resident's SDM outside the home, that they had asked the registered staff to print the resident's eMAR and written care plan for the family; and that they presented both documents to the family while attempting to explain that the resident would be discharged from the home. RFEC #121 acknowledged that it was possible that SDM #148 did not clearly grasp what was being communicated considering the environment, and the fact that they were wearing a face mask and face shield while discussing the information.

RFEC #121 and #122 both acknowledged that the resident was discharged from the home during the outbreak. During a separate interview, RFEC #122 verified that they had two separate telephone conversations with the resident's SDMs prior to the resident's discharge and verified that the family stated they did not want the resident to be discharged from the home.

Therefore, the licensee failed to ensure that if resident #015 and #016 were unable to return to the home because of an outbreak of disease in the home or an emergency in the home; or if the resident's substitute decision-maker had notified the Administrator that the resident intended to return to the home, the resident was not discharged from the home.

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 if the resident is unable to return to the home because of an outbreak of disease in the home; or if the resident's substitute decision-maker had notified the Administrator that the resident intended to return to the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Findings/Faits saillants :

1. 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 applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive #3, the licensee was required to ensure that, as of the issuance date of April 15, 2020; updated on May 21, 2020, referenced in section 77.7(6), paragraph 10 of the Health Protection and Promotion Act, short-stay absences from the long-term care home was not permitted.

The MLTC received a complaint related to resident #015's discharge from the long-term care home.

Record review of the home's electronic PCC progress notes indicated, and staff interviews confirmed that resident #015 was permitted to leave the home on a short stay vacation leave of absence during the time that the Directive was effective for a specified amount of days.

During an interview, the home's RFEC #121 and ED #101 both verified that the home did not follow the Minister's Directive by permitting the resident to leave the home on a short stay vacation leave of absence.

Issued on this 17th day of September, 2020

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

Original report signed by the inspector.