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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
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5700, rue Yonge 5e étage
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 06, 2022	2021_833763_0023 (A1)	016064-20, 022030-20, 026119-20, 010459-21, 014061-21, 017194-21	Critical Incident System

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

Amended by IANA MOLOGUINA (763) - (A1)

Amended 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): November 4, 5, 8, 9, 12, 16, 17, 18, and 19, 2021.

The following intakes were completed during this Critical Incident System (CIS) Inspection:

- Log #016064-20, CIS #2945-000027-20 was related to medication management.

The following intakes were related to falls:

- Log #010459-21, CIS #2945-000040-21,

- Log #014061-21, CIS #2945-000050-21,

- Log #017194-21, CIS #2945-000057-21,

- Log #026119-20, CIS #2945-000001-21, and

- Log #022030-20, CIS #2945-000054-20.

PLEASE NOTE: A Compliance Order (CO) related to O. Reg. 79/10, s. 114. (3) (a) was identified in this inspection and has been issued in Inspection Report 2021_833763_0022, dated December 10, 2021, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and residents' family members.

During the course of this inspection, the inspectors reviewed residents' clinical records and conducted observations, including staff-resident interactions, meal observations and resident care provisions.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
2 WN(s)
1 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	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. 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 a resident in accordance with the directions for use specified by the prescriber.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to a medication incident. The report indicated that RPN #106 administered a higher dose of medication than required to manage the

medical condition.

The home’s investigation records and progress notes indicated RPN #106 contacted RN #107 when the resident's condition declined. The RN advised the RPN to notify the physician, and the RPN contacted the physician and obtained a new order. The notes indicated the physician gave an order for immediate administration of the medication but the RPN administered a much larger dose by mistake.

The physician was notified about the error and a new order to check the resident’s condition every 15 minutes and administer a counteractant if needed was obtained. The resident was not affected by the error as corrective measures were taken immediately.

Interview with the DOC indicated that staff members were expected to administer medications as specified by the prescriber and confirmed RPN #106 did not follow the prescriber’s direction. The DOC further indicated that the RPN did not transcribe the order in the physician order section of the paper chart and the resident’s electronic medication administration record (eMAR).

Failure to follow the physician’s order or administering incorrect medication dosages, would increase the risk for adverse medication outcomes and compromise the safety and well-being of residents.

Sources: Resident's eMAR, CIS #2945-000034-21, the home's investigation records, progress notes, and interview with the DOC. [s. 131. (2)]

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.

The home’s “Medical Pharmacy Medication Incident” record indicated that RPN #108 did not administer a medication to the resident. During the home’s investigation, RPN #108 indicated that the medication was not available in the resident’s’ medication bin. The home's investigation notes indicated that the RPN was aware that the medication was available in the home’s “Emergency Drug Box”, but failed to access, dispense and administer the medication.

Interview with the DOC indicated that staff members were expected to administer medications as specified by the prescriber and confirmed RPN #106 did not follow

the prescriber’s direction. In the event where a medication was missing, staff members were expected to access the Emergency Drug Box or contact the Medical pharmacy to obtain the missing dosage and notify the physician.

Sources: Resident's eMAR , investigation records, progress notes and interview with the DOC. [s. 131. (2)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director of an incident that caused injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital within the required time frame.

O. Reg. 79/10, s. 107. (3.1) indicated that, where an incident occurred that caused an injury to a resident for which the resident was taken to a hospital, but the licensee was unable to determine within one business day whether the injury resulted in a significant change in the resident's health condition, the licensee was to:

a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury resulted in a significant change in the resident's health condition; and

b) where the licensee determined that the injury resulted in a significant change in the resident's health condition or remained unsure, inform the Director of the incident no later than three business days after the occurrence of the incident.

A CIS report was submitted to the MLTC regarding a fall of the resident that resulted in a transfer to hospital. The resident's clinical records indicated that the nursing staff accessed the resident's electronic hospital records a week after the incident and determined that the resident had surgery; they then submitted the CIS report to the Ministry.

The home's DOC acknowledged that the nursing staff should have contacted the hospital to determine if the significant change occurred within three calendar days of the incident, and reported the incident within three business days if they weren't able to determine whether a significant change occurred.

Sources: resident's clinical records (care plan, progress notes, assessments, risk management assessments, PointClickCare profile); CIS #2945-000050-21, staff interviews (DOC #104). [s. 107. (3.1)]

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 in informing the Director of an incident that caused injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital within the required time frame, to be implemented voluntarily.

Issued on this 6 th day of January, 2022 (A1)

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

Original report signed by the inspector.

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by IANA MOLOGUINA (763) - (A1)
Inspection No. / No de l'inspection :	2021_833763_0023 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	016064-20, 022030-20, 026119-20, 010459-21, 014061-21, 017194-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 06, 2022(A1)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Woodbridge Vista Care Community 5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lorraine Gibson

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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 # / No d'ordre: 001 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with s. 131. (2) of O. Reg. 79/10.

Specifically, the licensee must prepare, submit and implement a plan to ensure staff are following the home’s policies and procedures for medication administration. The plan must include but is not limited to:

- Staff education on the home's current policies and procedures for drug administration.
- Track and monitoring of medication incidents with ensuring follow up on any actions taken to address any noted concerns.

Please submit the written plan for achieving compliance for inspection #2021_833763_0023 to Iana Mologuina, LTC Homes Inspector, MLTC, by email to torontoSAO.moh@ontario.ca by December 21, 2021.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

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

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to a medication incident. The report indicated that RPN #106 administered a higher dose of medication than required to manage the resident's medical condition.

The home's investigation records and progress notes indicated RPN #106 contacted RN #107 when the resident's condition declined. The RN advised the RPN to notify the physician, and the RPN contacted the physician and obtained a new order. The notes indicated the physician gave an order for immediate administration of the medication but the RPN administered a much larger dose by mistake.

The physician was notified about the error and a new order to check the resident's condition every 15 minutes and administer a counteractant if needed was obtained. The resident was not affected by the error as corrective measures were taken immediately.

Interview with the DOC indicated that staff members were expected to administer medications as specified by the prescriber and confirmed RPN #106 did not follow the prescriber's direction. The DOC further indicated that the RPN did not transcribe the order in the physician order section of the paper chart and the resident's electronic medication administration record (eMAR).

Failure to follow the physician's order or administering incorrect medication dosages, would increase the risk for adverse medication outcomes and compromise the safety and well-being of residents.

Sources: Resident's eMAR, CIS #2945-000034-21, the home's investigation records, progress notes, and interview with the DOC.

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.

The home's "Medical Pharmacy Medication Incident" record indicated that RPN #108 did not administer a medication to the resident. During the home's investigation, RPN #108 indicated that the medication was not available in the resident's' medication bin. The home's investigation notes indicated that the RPN was aware that the medication was available in the home's "Emergency Drug Box", but failed to access, dispense and administer the medication.

Interview with the DOC indicated that staff members were expected to administer medications as specified by the prescriber and confirmed RPN #106 did not follow

the prescriber's direction. In the event where a medication was missing, staff members were expected to access the Emergency Drug Box or contact the Medical pharmacy to obtain the missing dosage and notify the physician.

Sources: Resident's eMAR , investigation records, progress notes and interview with the DOC.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm because two of the three residents were at risk of adverse health events due to the medication administration errors noted.

Scope: The scope of this non-compliance was a pattern because two of the three residents reviewed experienced medication administration errors during this inspection.

Compliance History: 77 written notifications (WN), 35 voluntary plans of correction (VPC), 19 compliance orders (CO), and four director referrals (DR) were issued to the home related to different sub-sections of the legislation in the past 36 months. (645)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 10, 2022(A1)

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6 th day of January, 2022 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by IANA MOLOGUINA (763) - (A1)

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