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
Mar 4, 2022	2022_891649_0004	020825-21, 000423-22, 000428-22, 000429-22, 001347-22, 001352-22	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

JULIEANN HING (649), PRAVEENA SITTAMPALAM (699), STEPHANIE LUCIANI (707428)

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): February 10, 11, 14, 15, 16, 17, 18, 23, and off-site on February 22, 2022.

The following intakes were completed during this Critical Incident System (CIS) Inspection:
Log #020825-21 related to a communicable disease outbreak in the home.
Logs #000423-22, #000429-22, #001347-22, and #001352-22 related to medication management system.
Log #000428-22 related to safe and secure home.

PLEASE NOTE: A Written Notification (WN) and a Voluntary Plan of Correction (VPC) related to O. Reg. 79/10, r. 8. (1) (b) identified in a concurrent inspection #2022_891649_0003 were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Directors of Care (DOCs), Assistant Directors of Care (ADOCs), Registered Nurses (RNs), Infection Prevention and Control (IPAC) Lead, Registered Practical Nurses (RPNs), and residents.

During the course of the inspection the inspectors observed staff to resident interactions, reviewed residents' clinical records, staffing schedules and observed infection prevention and control (IPAC) practices.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 114. (3)	CO #002	2021_833763_0022	707428
O.Reg 79/10 s. 131. (2)	CO #001	2021_833763_0023	649
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2021_833763_0022	649

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the home's Controlled Substances and Narcotic Counts policy included in the Medication management system were complied with.

O. Reg. 79/10, s.114 (1) required the licensee to develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

O. Reg. 79/10, s. 114 (2) required the licensee to develop written policies and protocols for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home

O. Reg. 79/10, s. 127 requires that a policy is developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern changes in the administration of a drug due to modifications of directions for use made by a prescriber, including temporary discontinuation.

(i) Specifically, staff did not comply with the home's policy Controlled Substances and Narcotic Counts, dated May 2019.

The home's policy Controlled Substances and Narcotic Counts, directed registered staff to do the following:
- Conduct a controlled substance and narcotic shift count between each shift change by the incoming and outgoing nurse.
- Sign the controlled substance/narcotic count record sheet after count is completed by

incoming and outgoing nurse.
- Report any discrepancies between shifts to the Director of Care or designate immediately and complete an internal incident report.

In January 2022, the Registered Practical Nurse (RPN) provided a verbal count of the narcotics to incoming RPN at shift exchange. Both RPNs acknowledged that a narcotic count was not completed together at shift exchange, and did not sign off verifying the narcotic balance on both the narcotic count sheet and a resident's count sheet.

The incoming RPN acknowledged that they completed the narcotic count alone, noted there was a discrepancy in the count and, altered the narcotic record sheet count in an attempt to change the count numbers. The RPN acknowledged that they did not inform the nurse manager on-call of the discrepancy immediately.

The Director of Care (DOC) acknowledged that registered staff must conduct a controlled substance/narcotic count between each shift exchange with the incoming and outgoing nurse. The DOC acknowledged that the RPNs did not follow the home’s controlled substance and narcotic count policy.

(ii) Specifically, staff did not comply with the home’s policy The Medication Pass, dated April 2021.

The home’s Medication System: Medication Pass policy indicated that:
- Registered staff were to document the administration of narcotic and controlled substances in the resident’s medication administration record (MAR).
- Pre-pouring of medications were not allowed, and staff were to handle one resident’s medication at a time.

The RPN acknowledged they had pre-poured three residents’ narcotic medications at one time for administration. The DOC acknowledged that staff were to pour medications for one resident at a time, and that the RPN did not follow the home’s Medication Pass policy.

The RPN acknowledged that they administered the medication to the resident, and had not documented the medication administration on the resident's MAR.

The DOC advised that registered staff should have documented the administration of the controlled substances/narcotics on the resident’s MAR, each time a dose was

administered. The DOC acknowledged that the RPN did not follow the home's Medication Pass policy.

Failure to ensure that staff adhere to the home's medication pass policy can lead to medication errors and risk of harm to the residents.

Sources: (i) Critical Incident System (CIS) report, the home's investigation records, Controlled Substances and Narcotic Counts policy (#VIII-E-10.40, revised May 2019), medication incident report, shift change monitored medication count sheet, and interviews with the DOC and RPNs.

Sources: (ii) CIS report, resident's MAR, the home's investigation records, The Medication Pass policy (Section 3, Policy 3-6, revised April 2021), and interviews with the DOC and RPNs. [s. 8. (1) (b)]

2. The licensee has failed to ensure the Readmission of Residents from Hospital policy and procedure included in the required Medication Management System was complied with, for the resident.

(iii) Specifically, staff did not comply with the home's policy and procedure: Readmission of Residents from Hospital, dated February 2017.

As per the policy, the following was required to be completed when a resident is readmitted from hospital:
-The nurse is to call pharmacy (ideally before or) once the resident has returned and forward any discharge orders to the pharmacy and the physician (if not already signed);
-medication reconciliation is completed by comparing readmission orders and hospital MAR to orders on previous MAR in the home and bringing any difference to the attention of the nurse, pharmacist and prescriber;
-prescriber reviews and authorizes all readmission orders upon readmission from hospital; and
-review admission orders carefully especially medications on hold during resident's stay in hospital. Hold orders will need to be discontinued or reactivated.

Staff stated that the above-mentioned steps would be immediately completed when the resident is readmitted to the home.

The Director received a complaint regarding an agency staff not completing the

readmission process for a resident.

The resident returned from the hospital with a suggestion from the emergency physician to hold a medication as it may have contributed to the resident's transfer to hospital. The RPN who readmitted the resident did not communicate the suggestion from the hospital to the on-call physician or the nurse manager. They left a note in the communication binder for the following shift to review the hospital orders. The resident was administered this medication at its scheduled time, and again the following day by a different RPN. The Nurse Practitioner (NP) reviewed the resident's discharge notes the next day and put the medication on hold, and the physician discontinued the medication two days later. The resident was monitored for three shifts, and there was no harm to the resident as a result of taking this medication that should have been held.

The DOC confirmed the RPN who readmitted the resident did not comply with the Readmission of Residents from Hospital policy as they did not complete the above mentioned steps. There was an increased risk to the resident when the nurse who readmitted them did not comply with the policy.

Sources: The resident progress notes and medication administration record (MAR); discharge notes; Readmission of Residents from Hospital, policy 7-5, dated February 2017; interviews with the RPN, DOC, and other staff. [s. 8. (1) (b)]

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 the plan, policy, protocol, procedure, strategy or system put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the home's infection prevention and control program.

Observations of the home's hand hygiene practices and use of personal protective equipment (PPE) were as follows:

(i) On February 10, 2022, a staff member entered a resident's room without performing hand hygiene. Then they touched the resident's side table, and exited the resident's room, without performing hand hygiene. The same staff member entered another resident's room without performing hand hygiene, and collected two dirty cups.

The home's hand hygiene policy directed staff to follow the four moments of hand hygiene and clean their hands before and after contact with the resident's environment.

(ii) On February 10, 2022, two staff members were assisting two residents on droplet contact precautions with feeding and were observed not wearing gloves or gown. A housekeeping staff was observed not wearing gloves or gown while in a resident's room who was on droplet contact precautions.

Infection Prevention and Control (IPAC) Lead acknowledged that the above mentioned staff should have cleaned their hands, and wear the required PPE when assisting residents, or cleaning resident's rooms who are on droplet contact precautions.

Failure to ensure that staff implement the home's infection prevention and control program may lead to the spread of infectious diseases.

Sources: (i) Observations on February 10, 2022, review of the home's hand hygiene policy #IX-G-10.10, last revised on December 2021, and interview with the IPAC Lead.

Sources: (ii) Observations on February 10, 2022, and interview with the IPAC Lead. [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every residents right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, was fully respected and promoted.

On February 17, 2022, observed the MAR screen open displaying a resident's personal health information. Two residents were nearby: one in a wheelchair and the other ambulating past the opened screen. Failure of staff to lock the MAR screen puts resident's personal health information at risk of being read by others.

The RPN acknowledged the above observation. The DOC advised that the MAR screen should have been locked to protect the resident's personal health information.

Sources: Observation of the unlocked MAR screen on February 17, 2022, acknowledged by the RPN, and interview with DOC. [s. 3. (1) 11. iv.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

On February 17, 2022, observed the medication cart unlocked, and resident's medications accessible. Two residents: one in a wheelchair and the other ambulating past the unlocked medication cart. The RPN was observed inside a resident's room with the door partially closed. Failure of staff to lock the medication cart when unattended allows anyone passing by to access residents' medications.

The RPN apologized for leaving the medication cart unlocked when they had gone into a resident's room. The DOC advised that the medication cart should be locked at all times for safety.

Sources: Observation of the unlocked medication cart on February 17, 2022, acknowledgement by the RPN, and interview with the DOC. [s. 129. (1) (a)]

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 the correct dose of lorazepam was administered to the resident in accordance with the directions for use specified by the prescriber.

The following is further evidence to support the order that was initially issued on December 10, 2021, during inspection #2021_833763_0023 to be complied by February 10, 2022.

The resident was scheduled to receive one dose of a medication at bedtime and received two doses instead. The home's investigation records indicated that the resident received two doses of the medication administered by two RPNs instead of one dose.

Both RPNs acknowledged that they each administered one dose of the medication to the resident on their shift.

Failure to ensure that the resident received the correct dose of the medication as specified by the prescriber, may lead to adverse medication effects and risk of harm to the resident.

Sources: CIS report, the home's investigation records, medication incident report, resident's MAR, progress notes, and interviews with the DOC and RPNs. [s. 131. (2)]

Issued on this 17th day of March, 2022

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

Original report signed by the inspector.