Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: July 24, 2023

Inspection Number: 2023-1429-0006

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Woodbridge Vista Care Community, Woodbridge

Lead Inspector	**Inspector Digital Signature**
Adelfa Robles (723)	Adelfa P Robles Digitally signed by Adelfa P Robles Date: 2023.08.01 08:44:57 -04'00'

Additional Inspector(s)
Noreen Frederick (704758)
Dorothy Afriyie (000709)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 6-7, 10-14, 2023

The following intake(s) were inspected:

- Intake: #00089014 – Follow-up inspection to Compliance Order (CO) #001: FLTCA, 2021 – s. 6 (7), related to Plan of Care
- Intakes: #00089308 and #00089337 – were complaints related to alleged neglect
- Intake: #00089489 – related to alleged neglect
- Intake: #00091023 – related to a fall with injury
- Intake: #00091255 – was a complaint related to a fall with injury

The following intake(s) was completed in this inspection:

- Intake: #00090647 – related to a fall with injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1429-0005 related to FLTCA, 2021, s. 6 (7) inspected by Noreen Frederick (704758)

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

Falls Prevention and Management
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Resident Care and Support Services
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that the written plan of care for a resident set out the planned care for the resident regarding their discharge due to infection.

Rationale and Summary
A resident was prescribed with antibiotics for their infection with discharge. The staff noted the discharge which they need to clean on a regular basis.

Staff described the discharge with characteristic color and odor that would dry on the resident's skin. The discharge was more pronounced when the resident was in bed. Staff stated the discharge was observed everyday on all shifts.

There was no specific intervention care planned to manage the resident's discharge due to infection. The home stated that staff would wipe down the discharge but there was no special treatment or procedure care planned to manage the discharge.

Because there was no planned care to manage a resident's discharge due to infection there was a risk to the resident's health and well-being.

Sources: A resident's clinical records and staff interviews.

[723]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

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

Rationale and Summary
A staff referred a resident to the physician. The physician reviewed the medication order and noted a discrepancy. The staff compared the medication order in Electronic Medication Administration Record (EMAR) with the medication pouch and confirmed with the pharmacy that the resident was receiving twice the dose of what was originally prescribed.

The home confirmed that a resident was receiving an incorrect dose of their medication for nine months. The home also stated that nurses were expected to compare the medications received in the medication pouch before confirming the order in the EMAR.

Failure to administer medications as prescribed increased the risk of medication side effects to a resident.

Sources: A resident's clinical records, Medication Incident Number: MEDINC85965, interviews with physician and staff.

[723]

COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit and implement a plan to ensure that residents in the home with infection requiring treatment are not neglected by the licensee or staff. The plan must include but is not limited to:

1) Assessment and reassessment procedures for residents receiving antibiotic therapy for infections;
2) Review of the roles and responsibilities of registered staff, Infection Prevention and Control (IPAC) Lead, Behavioural Supports Ontario (BSO) Lead related to assessments and reassessments of residents with infection requiring treatment;
3) Education for Registered staff on assessment, monitoring and communication protocols for residents with infection requiring treatment;
4) Maintain a documented record of the content of education provided, including the date, staff attendance and the individual who provided the education;
5) An audit tool to monitor and document implementation of the assessments and reassessments of residents with infection requiring treatment. Audits must be completed for a minimum of four weeks or until 100% compliance is reached;
6) Maintain a document record of audits completed to include but not limited to person(s) completing audit, resident audited, outcome of the audit and any actions taken in response to the audit findings.

Please submit the written plan for achieving compliance for inspection 2023-1499-0006 to Adelfa Robles, LTC Homes Inspector, MLTC by email by August 8, 2023.

Grounds
The licensee has failed to ensure that a resident was not neglected when they had an infection.

Section 7 of the Ontario Regulation 246/22 defines neglect as "failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Rationale and Summary

A resident was reported with discharge due to infection for 16 days. On a specified date, a staff observed a visible change in the appearance of the infected area. The resident was transferred to hospital for treatment and returned to the home after 13 days with new diagnoses.

Staff stated the discharge from infection was observed everyday and more noticeable when the resident was in bed. Staff also stated the resident was observed with increased behaviours.

Staff stated there were no specific assessment tools utilized in the home when completing an assessment for a resident with a specified infection. They stated for any resident with infection they would document under Infection Notes.

Infection Notes from a specified period, all indicated a resident was observed with discharged of a certain color. There was no follow up from the home's infection control lead.

The resident was referred for an assessment and further reassessment to a Nurse Practitioner (NP). Following each assessment an order for a medication to treat the infection was made. The NP was not able to perform a complete exam using an instrument twice because of the resident's behaviours. There were no further attempts from the NP to perform a complete assessment.

A behavior referral was submitted for the resident for new onset behavior. The referral was followed up 34 days after it was initiated.

The home stated there were no specific assessments for staff to complete when assessing a resident with a specified infection. Staff were expected to complete an Infection Note when documenting on residents with any infection. The Infection Notes were to be reviewed and analyzed daily by the home's infection control lead to determine if follow up action was required. The home also stated that for residents with new or escalating behaviours staff were expected to reapproach the resident, complete a referral, and involve the family members as required.

Due to pattern of inaction a resident's health and well-being was jeopardized, requiring hospitalization.

Sources: A resident's clinical records and staff interviews.

[723]

This order must be complied with by September 4, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
CO #001 issued on September 3, 2021 in Inspection #2021_796646_0011
CO #001 issued on January 26, 2023 in Inspection #2022_1429_0003.

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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