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: October 31, 2023

Inspection Number: 2023-1429-0008

Inspection Type:
Complaint
Follow up

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

Long Term Care Home and City: Villa Santa Maria Community, Woodbridge

Lead Inspector	**Inspector Digital Signature**
Reji Sivamangalam (739633)	Reji K Sivamangalam Digitally signed by Reji K Sivamangalam Date: 2023.11.02 10:50:11 -04'00'

Additional Inspector(s)
Yannis Wong (000707)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 12-13, 16-20 and 23, 2023

The following intake(s) were inspected:

- Intake: #00093024- Follow-up inspection to Compliance Order (CO) #0001: FLTCA, 2021, s. 24 (1), related to Duty to Protect
- Intakes: #00095940, #00098443 and #00098956 were complaints related to multiple care concerns.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1429-0006 related to FLTCA, 2021, s. 24 (1) inspected by Yannis Wong (000707)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Staffing, Training and Care Standards
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication management system

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)

The licensee has failed to ensure that registered staff verified two identifiers before administering a medication to a resident.

Rationale and Summary

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that there are policies developed for the medication management system to ensure the accurate administration of drugs, and that they are complied with. Specifically, the staff did not comply with the home's medication pass policy, as it required staff to use two person-specific client identifiers to ensure residents receive the medication intended for them.

On a specific date, the resident was administered medications which were not intended for them.

The staff acknowledged that they did not use two person-specific identifiers to verify the resident's identity before administering the medications.

Associate Director of Care (ADOC) confirmed that the staff were required to verify the resident's identity by two person-specific identifiers before administering medications.

There was a risk of harm to the resident when medications not intended for them were administered.

Sources: Resident's clinical records, home's policy**,** medication incident report, and interviews with staff members.

[739633]