Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 12, 2018	2017_527665_0012	024725-17	Resident Quality Inspection

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

JOY IERACI (665), THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 30 and 31, 2017, November 1, 2, 3, 6, 7, 8, 9, 10, 14, 15, 16, 17, 20 and 21, 2017.

The following Complaint Intake Log #034633-16 related to administration of drugs and Log #003051-15 related to duty to protect were inspected concurrently with the Resident Quality Inspection (RQI).

The following Follow-Up Log #004870-17 was inspected.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Associate Directors of Care (ADOC), Ex-Director of Resident Programs, Registered Dietician (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Behavioural Support Ontario (BSO) RPN, Staff Educator, Personal Support Workers (PSWs), Residents' Council representative, Family Council representative, residents and families.

The inspectors also conducted a tour of the home including resident home areas, medication administration observations, staff and resident interactions, provision of care observations, reviewed clinical health records, reviewed meeting minutes, training records, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **3 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. 54.	CO #001	2016_324535_0009	665

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The skin and wound IP was triggered from stage one of the resident quality inspection (RQI) related to altered skin integrity for resident #001.

Review of the resident's clinical records revealed the resident had two areas of altered skin integrity which deteriorated over two months.

Review of the written plan of care and physician order on an identified date in 2017, indicated resident #001 was to use an identified appliance at all times for their altered skin integrity.

Observations conducted on two identified dates in 2017, revealed resident was not using the identified appliance on three occasions.

Interviews with registered practical nurses (RPNs) #103 and #110 and personal support workers (PSWs) #104, #105 and #111, indicated it is the expectation of the home for staff to follow the plan of care of residents. The staff acknowledged the resident was not using the identified appliance as set out in the plan of care.

Interview with the Associate Director of Care (ADOC)/Skin and Wound Lead #119 indicated it is the home's expectation for staff to follow the plan of care of residents. The ADOC acknowledged resident #001's plan of care was not provided as specified in the

plan regarding the identified appliance [s. 6. (7)]

2. Review of the physician's orders on an identified date in 2017, for resident #001 revealed a specified treatment order for one of their areas of altered skin integrity.

During an observation conducted on an identified date in 2017, with RPN #118, the treatment that was removed from one of the resident's area of altered skin integrity did not follow the treatment order. Interview with RPN #118 indicated it is the home's process to follow the treatment orders and acknowledged the treatment order for the area of altered skin integrity was not followed for resident #001.

Interview with the ADOC/Skin and Wound Lead #119 indicated that treatment orders for altered skin integrity are to be followed as directed. The ADOC acknowledged the treatment order was not provided to the resident as specified in the plan. [s. 6. (7)]

3. Resident #013 was admitted to the home on an identified date in 2017, with an identified area of altered skin integrity. Review of the electronic treatment administration record (ETAR) for an identified month in 2017, revealed an identified treatment order for the altered skin integrity to be completed every two days and as required.

During an observation conducted on an identified date in 2017, with RPN #117, the treatment that was removed and applied was not as prescribed.

Interview with RPN #117 indicated it is the home's process to follow the treatment orders for altered skin integrity and acknowledged the treatment order was not followed as per the plan of care for resident #013.

Interview with ADOC/Skin and Wound Lead #119 indicated that treatment orders for altered skin integrity are to be followed as directed. The ADOC acknowledged the treatment order was not provided to the resident as specified in the plan. [s. 6. (7)]

4. The licensee failed to ensure when a resident is reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The responsive behaviour inspection protocol was initiated for resident #011 as a result of a follow up inspection related to compliance order (CO) #001 issued to the home

under O.Reg 79/10. s. 54. (b) on February 23, 2017, from inspection #2016_324535_0009.

Review of resident #011's clinical records revealed the resident demonstrated an identified responsive behaviour and had a history of another identified responsive behaviour towards co-residents. Review of the written responsive behaviour plan of care included two identified interventions which were implemented on an identified date in 2016. The plan of care was revised on three identified dates in 2017, over a nine month period with interventions.

Review of resident #011's progress notes and responsive behaviour assessments revealed that resident had been followed and assessed by the Behavioural Support Ontario (BSO) nurse and provided interventions for staff to follow on four identified dates over a five month period in 2017.

A review of the resident's progress notes during the time periods between the BSO assessments revealed that over a four month period in 2017, there were seven documented incidents where resident #011 demonstrated the identified responsive behaviour towards co-residents.

Another BSO assessment on an identified date in 2017, directed staff to continue with the current plan of care for resident #011.

After the four month period mentioned above, there were two additional documented incidents where the resident demonstrated the identified responsive behaviour towards co-residents over another two month period in 2017.

A review of the BSO assessments on two identified dates in 2017, directed staff to continue to implement the two identified interventions noted above when resident #011 demonstrated the identified responsive behaviour towards co-residents.

Interviews with PSWs #121 and #136 and RPNs #122 and #133 revealed resident #011 had demonstrated the identified responsive behaviour towards co-residents. The staff indicated resident #011 also demonstrated three identified responsive behaviours. The staff indicated the identified trigger for resident #011's responsive behaviours. RPNs #122 and #133 indicated the interventions in place to manage resident #011's responsive behaviour were the two identified interventions mentioned above. When asked what the first identified intervention entailed, staff indicated they would implement

when they were near the resident. This would include times when they were documenting, or when the resident is near an identified location in the resident home area.

Interviews with RPNs #122 and #133 indicated the two identified interventions had not been effective in preventing the identified responsive behaviour towards co-residents and new approaches have not been considered when the plan of care was revised.

Interview with the home's internal BSO RPN #127 who assessed the resident and provided interventions to staff on four identified dates over a five month period in 2017, indicated resident #011 had been on their caseload since an identified month in 2016. When asked what the first identified intervention entailed, the BSO RPN indicated that staff would implement the intervention when they see the resident in an identified location in the resident home area, keep the resident engaged in an identified location, during documentation and when the resident demonstrated their responsive behaviour towards co-residents. When the BSO RPN was asked if the interventions were effective in managing resident #011's responsive behaviours, the BSO RPN indicated the two identified interventions may not have been the most appropriate interventions as it was not working to prevent the responsive behaviours and that the plan of care had not been effective. The BSO RPN acknowledged that when the resident was reassessed, no new interventions or approaches had been identified nor the plan of care reviewed and revised for resident #011.

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 care set out in the plan of care is provided to resident as specified in the plan
- to ensure when a resident is reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

According to O.Reg 79/10, r. 134 (c), Every licensee of a long-term care home shall ensure that, there is, at least quarterly, a documented reassessment of each resident's drug regime.

The home uses Medical Pharmacies medication management policies and procedures. Medical Pharmacies policy #8-5 titled Physician's Medication Review dated February 2017, indicated under description number two, "Legal requirements state that all orders must be reviewed by the physician, every three months. Any orders not included on the "Medication Review" once it is signed by the physician, are automatically discontinued. Note the directive at the top of the form which stated "Discontinue All Previous Orders". The policy under procedure directs staff to precheck the review prior to physician review. Number four and five under procedure indicated, "Check orders on the "Medication Review" against the physician's orders in the resident's chart going back to the date on which the MAR sheets were last checked against the physician's orders. Update the "Medication Review" form by making all changes necessary to reflect all current physician's orders."

Review of the physician orders for resident #013 revealed an identified treatment order for the area of altered skin integrity in the current quarterly physician medication review for a specified period and signed by the physician on an identified date in 2017. Further

review revealed a different treatment was ordered by the physician a month prior.

Review of the ETAR for an identified month in 2017, revealed the treatment order for the area of altered skin integrity was the treatment order from the month prior noted above.

Interview with RPN #117 indicated nurses must check the quarterly medication review to ensure all the information including medication and treatments are correct before the physician reviews and signs the review. The RPN reviewed the quarterly medication review and the current ETAR for resident #013 and indicated the treatment order on the quarterly medication review was incorrect. The RPN indicated the correct treatment order of the area of altered skin integrity was on the current ETAR. RPN #117 acknowledged when the quarterly medication review was checked by the nurse prior to the physician review, the correct treatment order for the area of altered skin integrity was missed.

Interview with the ADOC/Skin and Wound Lead #119 indicated it is the home's process for the nurse on the unit to prepare the quarterly review prior to the physician's review and signature. The ADOC stated the nurses must ensure the orders on the quarterly medication review are the most current orders and the nurses must add orders that are not on the quarterly medication review prior to the physician's review and signature. The ADOC reviewed the quarterly medication review, physicians orders and the current ETAR for resident #013 and indicated the treatment order for the area of altered skin integrity on the quarterly medication review was incorrect and the correct treatment order was not transferred on the quarterly medication review. The ADOC acknowledged the staff did not follow the home's process when preparing the quarterly medication review.

2. According to O.Reg 79/10, s.114 (2), The licensee shall ensure that written policies and protocols are developed 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.

The home uses Medical Pharmacies medication management policies and procedures. Medical Pharmacies policy #8-3, titled Transcribing Prescriber's Orders to EMAR/MAR Sheet, dated February 2017, indicated all prescriber's orders are transcribed accurately and completely to the MAR or TAR. Medical Pharmacies provided the home an electronic medication administration record (EMAR) order processing flowchart for new orders titled, Sienna OM EMAR Order Processing Flowchart. The flowchart revealed new orders are processed by the nurse for the non medication portion of treatment

orders and wound care orders into the EMAR. Checks for all orders are to be completed and nurse check number one is to check physician's order to the EMAR entry; nurse check number two is to check physician's order to the EMAR entry and verify that the drug supplied by pharmacy matches the EMAR entry and the physician's order.

Resident #012 was admitted to the home on an identified date in 2017, with an identified area of altered skin integrity, which deteriorated two weeks later.

Review of the physician's orders on an identified date in 2017, revealed the current treatment order for the area of altered skin integrity.

Review of the ETARs on two identified months revealed the treatment order for the area of altered skin integrity did not reflect the current treatment order.

Interview with RPN #115 indicated it is the home's process for two checks to be done when there are new orders. The nurse who does the first check enters the treatment order into the ETAR and any medication part of the treatment order is processed by pharmacy. The nurse who does the second check ensures that the order in ETAR is correct and that any creams/ointments/medications that was ordered are in the resident's drawer in the treatment cart. RPN reviewed the physician's orders, ETARs for the two identified months, and indicated the current treatment order was not accurately transcribed into the EMAR for resident #012.

Interview with the ADOC/Skin and Wound Lead #119 indicated it is the home's expectation for treatment orders to be transcribed accurately into the ETAR by the nurses. The ADOC indicated pharmacy will process the medication portion of the order in the ETAR. After the ADOC's review of the physician's orders and the ETARs for the two identified months for resident #012, they indicated the current order was not transcribed properly by the nurses and it was the expectation for the nurse doing the second check to verify the order is correct in the ETAR and that the prescribed supplies were present in the unit.

3. According to O. Reg. 79/10, s.114 (1), every licensee of a long term care home shall develop an interdisciplinary management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The home's policy titled medication reconciliation, last reviewed January 17, 2017, indicated that part of the admission process will include: obtaining a medication history

from various sources (ie: discharge list from hospital or specialist, CCAC, MAR from another home, community pharmacy, prescription vials, family members/resident).

A complaint was called into the MOHLTC infoline on an identified date in 2016, regarding resident #021 receiving the wrong medications after being admitted to the home on an identified date in 2016. The home did not use the resident's most recent medication list to complete the resident's medication reconciliation.

Record review of resident #021's clinical record revealed they were admitted to the home on an identified date in 2016, from an identified facility. The clinical record contained two medications lists; one from the Community Care Access Centre's (CCAC) and the MAR from the identified facility dated with a specified period in 2016. Review of the resident's MARs for two consecutive months in 2016 revealed the medication list from CCAC was used for the medication reconciliation.

Interview with RPN #117 revealed that they completed resident #021's medication reconciliation and was unaware that the resident came from the identified facility. The RPN reported that they used the medication list from CCAC to complete the medication reconciliation, and the home's expectation is that all sources should be considered including family. RPN #117 stated that they did not attend the resident's admission assessment meeting because they were very busy on the unit. Registered Nurse (RN) #123 attended the admission assessment meeting and did not update RPN #117 that the resident was admitted from the identified facility and the CCAC medication list was not current. RPN #117 stated the lack of communication between them and RN #123 resulted in not following the home's medication reconciliation policy as all sources were not considered when determining the appropriate medication for resident #021.

Interview with RN #123 who no longer works at the home revealed that they did not remember the details of the above mentioned medication reconciliation involving resident #021.

Interview with the Executive Director (ED) and ADOC #124 revealed resident #021 was admitted to the home from the identified facility, and the registered staff did not use all sources to determine resident #021's appropriate medications as per the home's medication reconciliation policy. On an identified date in 2016, the resident's family member noticed the resident's level of functioning was different than before, medications were reviewed and the respective physician immediately made the required adjustments to the resident's medication regimen.

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 written policies and protocols for the medication management system is complied with, to be implemented voluntarily.

WN #3: 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 failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #012 was admitted to the home on an identified date in 2017, with an area of altered skin integrity, which deteriorated two weeks later.

Review of the physician's orders on an identified date in 2017, revealed the current treatment order for the area of altered skin integrity.

Review of the ETAR for an identified month in 2017, revealed the treatment order for the area of altered skin integrity did not reflect the current treatment order.

During a treatment observation conducted on an identified date in 2017, with RPN #115, the current treatment order was not performed on the resident's area of altered skin integrity.

Interview with RPN #115 indicated they did not review the treatment order for resident #013's area of altered skin integrity prior to doing the treatment. The RPN indicated they did not follow the treatment order as prescribed.

Interview with ADOC/Skin and Wound Lead #119 indicated that treatment orders for areas of altered skin integrity are to be followed as directed. The ADOC acknowledged the treatment order for resident #012's area of altered skin integrity was not administered in accordance with the directions for use specified by the prescriber, for 13 days after the current treatment order was prescribed.

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (5) The licensee shall ensure that a written record is kept of the results of the quarterly evaluation and of any changes that were implemented. O. Reg. 79/10, s. 115 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record is kept of the results of the medication management quarterly evaluation and of any changes that were implemented.

Record review of the home's medication management binder and Professional Advisory Committee (PAC) meeting minutes did not include a quarterly evaluation of the medication management system for the last quarter in 2016.

Interviews with ADOC #124 and the ED revealed the home completed the quarterly evaluation for the last quarter in 2016, but unable to locate the written record of it. [s. 115. (5)]

Issued on this 16th day of February, 2018

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

Original report signed by the inspector.