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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
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Original Public Report

Report Issue Date July 29, 2022
Inspection Number 2022_1429_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

Long-Term Care Home and City
Woodbridge Vista Care Community
5400 Steeles Avenue West Woodbridge

Lead Inspector
Noreen Frederick (704758)

Inspector Digital Signature
Noreen Frederick
Digitally signed by Noreen Frederick
Date: 2022.08.10 10:48:17 -04'00'

Additional Inspector(s)
Inspector #740880 (Christine Francis) was also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 23, 24, 2022.

The following intake(s) were inspected:

- Log #012041-22 (Complaint) related to Infection Prevention and Control

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

- Infection Prevention and Control (IPAC)
- Safe and Secure Home

INSPECTION RESULT

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

On June 23, 2022, a total of three point-of-care wall mounted hand sanitizer dispensers in the hallway of two different units were observed to be non-functional. This was brought to the Environmental Services Manager's (ESM) attention the same day.

Maintenance Aide #108 confirmed with the inspector on June 23, 2022, that a total of 14 point-of-care wall mounted hand sanitizer dispensers in the hallways were repaired throughout the building.

Sources: Inspector's observations, interviews with Maintenance Aide #108 and ESM) #111 and IPAC standards for Long-Term Care Homes.

Date Remedy Implemented: June 23, 2022

[704758]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (a)

The licensee has failed to ensure any surveillance protocols related to Rapid Antigen Test (RAT) issued by the Director for a particular communicable disease or disease of public health significance were complied with.

Rationale and Summary

Observations of the home's IPAC practices related to RAT identified that 11 staff and screeners #109 and #110, did not follow the manufacturer's instructions of the RAT device on June 23, 2022. 12 staff and two visitors were observed. The instructions on the RAT kit indicated that the swab with the collected specimen must stand in the extraction tube solution for two minutes prior to dispensing into the testing device. The staff members failed to keep the swab standing in the extraction tube for 2 minutes as per manufacturer's direction.

IPAC Lead #101 acknowledged that the manufacturer's instructions were not being followed to ensure accuracy of the test results.

Due to home not following the RAT device's instructions, there was a risk of harm to residents, staff and visitors related to spread of infectious disease.

Sources: inspector's observation, review of Rapid Response RAT device's instructions, interviews with IPAC Lead #101, screener #109 and #110.

[704758]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (7) 11

The licensee has failed to ensure that their hand hygiene program included access to hand hygiene agents with 70-90% Alcohol content.

Rationale and Summary

Observations of the IPAC practices related to residents' hand hygiene identified that staff used Purell wipes with 62% alcohol content on June 24, 2022 at lunch time on two units. IPAC Lead #101 acknowledged that the alcohol content should be minimum of 70%.

Due to the home not ensuring access to 70-90% Alcohol Based Hand Rub (ABHR), there was a potential risk of ineffective hand hygiene and risk for transmission of infectious agents.

Sources: inspector's observation, interview with IPAC Lead #101, and IPAC Standards.

[704758]

WRITTEN NOTIFICATION ADMINISTRATION, MISCELLANEOUS: BINDING ON LICENSEES

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s.184 (3)

The licensee has failed to ensure that staff and visitors wore medical masks while indoors as required by a Minister's Directive.

Rationale and Summary

(i) Observations on June 23, 2022, showed two visitors and one staff did not comply with universal masking requirements. While in a resident dining room, one visitor had no mask, one

visitor had the mask below the nose and Dietary Aide (DA) #107 had their mask below their chin. IPAC Lead #101 acknowledged that this practice was unacceptable and all staff and visitors were expected to keep their mask on at all times.

Due to the home not ensuring that the universal masking requirements as set out in the Minister's Directive were followed, there was risk of infection transmission.

Sources: inspector's observation, interview with IPAC Lead #101 and DA #107, and COVID-19 guidance document for long-term care homes in Ontario last updated June 11, 2022.

The licensee has failed to ensure that physical distancing was practiced in resident lounges as required by a Minister's Directive.

Rationale and Summary

(ii) Observations related to physical distancing identified that on June 23, 2022, three TV lounges on three different units had more residents/staff than posted capacity. TV lounges had a posted capacity of 10 persons, however 2A-TV lounge had total of 13 persons, 2B-TV lounge had total of 17 persons, and 1A-TV lounge had total of 12 person. IPAC Lead #101 acknowledged that staff were expected to ensure that two meter distance at all times is complied with.

Due to the home not ensuring physical distancing (a minimum of two metres or six feet) was practiced by all individuals at all times, except for the purposes of providing direct care to a resident, there was risk of infection transmission.

Sources: inspector's observation, interview with IPAC Lead #101, and COVID-19 guidance document for long-term care homes in Ontario last updated June 11, 2022.

The licensee has failed to ensure that IPAC audits were carried out weekly when in an outbreak as required by a Minister's Directive.

Rationale and Summary

(iii) Review of the home's self-assessment IPAC audits revealed that two audits were not completed. The home was in an outbreak from April 12 to June 9, 2022, and they were required to complete these audits weekly as per Minister's Directive. IPAC lead acknowledged that two audits (one in April and one in May 2022) were missed.

Due to the home not ensuring that the IPAC self-assessments are completed, there was a missed opportunity for the home to identify areas of concerns and implement changes to the home's IPAC program.

Sources: record review of IPAC self-assessment audits, interview with IPAC Lead #101, COVID-19 guidance document for long-term care homes in Ontario last updated June 11,

2022, and COVID-19 guidance document for long-term care homes in Ontario last updated June 11, 2022.

The Licensee has failed to ensure that RPN #114 was actively screened for symptoms and exposure history for COVID-19 as required by a Minister's Directive.

Rationale and Summary

(iv) Observations of the home's active screening identified that RPN #114 was not screened on June 23, 2022. RPN #114 worked a total of 17 shifts from May to June, 2022 and IPAC Lead #101 acknowledged that for all 17 shifts, they were not actively screened for symptoms and exposure history for COVID-19 before they allowed to enter the home.

Due to the home not actively screening RPN #114 for symptoms and exposure history for COVID-19 before they were allowed to enter the home, all residents and staff were put at risk of transmittable COVID19.

Sources: inspectors observations, RPN #114's schedule, interview with IPAC lead #101, and COVID-19 guidance document for long-term care homes in Ontario last updated June 11, 2022

[704758]

WRITTEN NOTIFICATION COOLING REQUIREMENTS

NC#005 WRITTEN NOTIFICATION PURSUANT TO FLTCA, 2021, S. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 24 (3)

The licensee has failed to ensure that the temperature required to be measured under subsection (2) was measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary

Review of the home's temperature logs indicated that air temperatures for total of seven days during the period May 15, 2022 to June 23, 2022 for the designated times were missed. ESM #111 acknowledged that the temperatures should have been taken for those designated times.

Due to home failing to take air temperatures, there was a potential risk for residents developing heat related illnesses.

Sources: home's temperature logs, and interview with ESM #111.
[704758]

COMPLIANCE ORDER CO#001 AIR TEMPERATURE

NC#006 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 24 (2)3.

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O.Reg.246/22, s. 24 (2) 3.

The licensee must:

1. Perform daily audits related to the home's air temperature in every designated cooling area of the home for one month.

2. The home must maintain a record of daily audits and results. Audit should include the date, name of the person completing audit, and any follow up completed .

Grounds

Non-compliance with: O. Reg. 246/22 s. 24 (2) 3.

The licensee has failed to ensure that the temperature are measured and documented in writing in every designated cooling area.

Rationale and Summary

Review of the home's temperature logs indicated that TV lounges on each unit were home's designated cooling areas, however no documentation of air temperatures for these rooms was found during the period May 15, 2022 to June 23, 2022. Maintenance aide #108 and Environmental Services Manager (ESM) #111 acknowledged that the temperatures were not taken and documented.

Due to home failing to take air temperature in the designated cooling areas, there was a risk for residents developing heat related illnesses.

Sources: home's temperature logs, interview with Maintenance Aide #108 and ESM #111.

[704758]

This order must be complied with by August 30, 2022

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COMPLIANCE ORDER CO#002 COOLING REQUIREMENTS

NC#007 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 23 (4)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O.Reg.246/22, s. 23 (4)

The licensee must:

1. Implement the home's written heat related illness prevention and management plan immediately, and at minimum through September 15, 2022, or as otherwise directed by the Regulation.

Grounds

Non-compliance with: O. Reg. 246/22 s. 23 (4)

The licensee has failed to ensure that the heat related illness prevention and management plan for the home was implemented during the period from May 15 to June 23, 2022.

Rationale and Summary

Review of the home's temperature logs revealed that during the period May 15, 2022 to June 23, 2022, there were 22 days where the temperature exceeded 26 degrees Celsius. These included residents' rooms and dining rooms which were home's designated cooling areas. ESM #111, Director of Care (DOC) #112 and Assistant Director of Care (ADOC) #113 acknowledged that the heat related illness prevention and management plan was not implemented for those days.

Due to home failing to implement the heat related illness prevention and management plan, there was a risk to residents' hydration status and other heat related illnesses.

Sources: home's temperature logs, and interviews with ESM #111, DOC #112 and ADOC #113.

[704758]

August 15, 2022

This order must be complied with by

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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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

Director

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Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: 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.