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

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Original Public Report

Report Issue Date: December 12, 2022	
Inspection Number: 2022-1243-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: ATK Care Inc.	
Long Term Care Home and City: Exeter Villa, Exeter	
Lead Inspector Ali Nasser (523)	**Inspector Digital Signature**
Additional Inspector(s) Melanie Northey (563)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 21, 22, 23, 24, 28, 29, 30 and December 1, 2022.

The following intake(s) were inspected:

- Intake: #00001726-Proactive Compliance Inspection

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

Infection Prevention and Control
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Quality Improvement
Skin and Wound Prevention and Management
Falls Prevention and Management
Pain Management

Safe and Secure Home
Resident Care and Support Services
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

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 shall implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

IPAC Standard 10.1 stated, "The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90 Alcohol Based Hand Rub (ABHR)."

Public Health Ontario Fact Sheet Titled, Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes stated "do not use expired product. Be sure to note product expiration date when selecting product."

There was one bottle of ProClean ABHR with no expiry date. The container was not used by any resident, staff, or visitor in the home. The home replaced the ABHR immediately when it was brought to their attention and checked the other containers of ABHR.

Sources: observations and staff interviews.

Date Remedy Implemented: November 22, 2022.
[523]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (a)

The licensee failed to post the Residents' Bill of Rights in a conspicuous and easily accessible location.

The Residents' Bill of Rights was posted on a bulletin board in North wing near the "BATH" room and was outdated and referenced the LTCHA 2007. The Director of Care (DOC) verified the 29 Residents' Bill of Rights were not posted as stated in the Fixing Long-Term Care Act, 2021. The DOC posted the Residents' Bill of Rights in the North hall in an easily accessible location to staff, visitors and residents.

Sources: Observation of the bulletin board and an interview with the DOC.

Date Remedy Implemented: November 30, 2022.
[563]

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (c)

The licensee failed to post the home's policy to promote zero tolerance of abuse and neglect of residents in a conspicuous and easily accessible location.

Across from the nursing station in a locked cabinet a sign stated, "Information available at Nurse's station: Ministry of Health and Long-Term Care Inspection reports, Prevention of Resident Abuse, Abuse reporting, Whistleblowing Protection policies, Minimal Restraint policies, Resident Satisfaction Survey results. Ask Registered staff for access or explanation".

The home's policy to promote zero tolerance of abuse and neglect of residents was in a binder at the nurses' station and referenced the LTCHA 2007. The DOC verified the home's policy to promote zero tolerance of abuse and neglect of residents was not posted in a conspicuous and easily accessible location and the copy of the policy was last revised July 2017. The DOC posted the home's policy to promote zero tolerance of abuse and neglect of residents last revised October 2022 in an easily accessible location to staff, visitors and residents.

Sources: Observation of the policy binder in the nurses' station and an interview with the DOC.

Date Remedy Implemented: November 30, 2022.
[563]

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (e)

The licensee failed to post the home's procedure for initiating complaints to the licensee in a conspicuous and easily accessible location.

Across from the nursing station in a locked cabinet a sign stated, "Information available at Nurse's station: Ministry of Health and Long-Term Care Inspection reports, Prevention of Resident Abuse, Abuse reporting, Whistleblowing Protection policies, Minimal Restraint policies, Resident Satisfaction Survey results. Ask Registered staff for access or explanation".

The written procedure and contact information for making complaints to the Director was outdated and listed the "Manager, Compliance Inspection, London Service Office" who has not worked for the Ministry of Long-Term Care for at least eight years, and the incorrect name of the "Ministry of Health and Long-Term Care" and incorrect Ministry address. The home's complaint process also identified the "Director of Performance Improvement and Compliance Branch" who no longer worked for the Ministry of Long-Term Care. DOC verified the complaint process should not identify specific Ministry staff for complaint reporting and the home's complaint process was in a binder at the nurses' station and was not posted in a conspicuous and easily accessible location. The DOC posted the home's updated complaints procedure in an easily accessible location to staff, visitors and residents.

Sources: Observation of the policy binder in the nurses' station and an interview with the DOC.

Date Remedy Implemented: November 30, 2022.
[563]

WRITTEN NOTIFICATION: Continuous Quality Improvement

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2)

The licensee has failed to ensure the continuous quality improvement (CQI) committee was composed of at least the specific following persons:
The home's Administrator, the home's Director of Nursing and Personal Care, the home's Medical Director, every designated lead of the home, the home's registered dietitian, the home's pharmacy service provider, or where the pharmacy service provider was a corporation, a pharmacist from the pharmacy service provider, at least one employee of the licensee who was a member of the regular nursing staff of the home, at least one employee of the licensee who had been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52, one member of the home's Residents' Council and one member of the home's Family Council, if any.

Rational and Summary:
The Administrator reviewed with inspector #523 the management meeting and CQI meeting agenda for March 2022. Administrator said they in addition to the DOC, IPAC lead, and Nurse Practitioner attended this meeting. Administrator said the CQI committee did not include the required stated personnel.

Sources: CQI meeting agenda and staff interview.
[523]

WRITTEN NOTIFICATION: Continuous Quality Improvement Interim report

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (5)

The licensee has failed to prepare an interim report on the continuous quality improvement initiative for the 2022-2023 fiscal year.

Rationale and Summary:
The Administrator said the home did not complete an interim report on the continuous quality improvement initiative for the 2022-2023 fiscal year.

Sources: Staff interview.
[523]

WRITTEN NOTIFICATION: Windows

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19

The Licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres (cm).

Rationale and Summary:
Observations during the inspection with DOC showed specific resident rooms with windows that opened to the outside more than 15 cm.

DOC the home did not ensure that those windows did not open more than 15 cm to the outside.

Sources: Observations and staff interviews.
[523]

WRITTEN NOTIFICATION: Air Temperature

NC #008 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 was 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:
A Maintenance worker said the home had installed the blue rover system in the designated cooling and common areas of the home. This system would measure and document the air temperature in those areas every hour and would send notifications if the temperature was outside of the specific set parameters. The home measures the air temperatures in all resident rooms once a day only.
The Maintenance worker said they did not know they had to measure the temperature in at least two resident bedrooms in different parts of the home at least once every morning, once every afternoon between 12 pm and 5 pm and once every evening or night.

The Administrator said they did not know they had to measure the temperature in at least two resident bedrooms in different parts of the home at least once every morning, once every afternoon

between 12 pm and 5 pm and once every evening or night. The Administrator said they would discuss with maintenance and ensure this would be done as required.

Sources: staff interviews.
[523]

WRITTEN NOTIFICATION: Air Temperature

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (4)

The licensee has failed to ensure that for every resident bedroom that was not served by air conditioning, the temperature was measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m.

Rationale and Summary:
A Screener said it was the screener's responsibility during the day to measure and document the temperature in every resident room between 12 p.m. and 5 p.m.

The Screener and inspector #523 reviewed the documented room temperatures for the months of September, October, and November 2022. The records showed that October 15, 16, 22, 23, 24, 29, 30 and 31 were not documented. The Screener said there was a confusion with the screener covering on those dates that resulted in the room temperatures not being taken.

Sources: room temperature records and staff interview.
[523]

WRITTEN NOTIFICATION: IPAC Lead

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 3.

The licensee has failed to ensure that the designated Infection Prevention and Control (IPAC) lead carried out the responsibility of overseeing the delivery of IPAC education to all staff, caregivers, volunteers, visitors, and residents.

Rationale and Summary:
IPAC lead said the Administrative Assistant (AA) was assigning the IPAC training through SURGE

Learning online and thought the Department lead would follow up to ensure training was completed. They did not know which staff was assigned or completed the training. IPAC lead said they were not aware they had to oversee the delivery of the IPAC training.

The DOC reviewed the SURGE Learning report that showed specific staff did not complete the IPAC training. The DOC said the AA was assigning the training to staff through SURGE Learning online. DOC said the IPAC lead did not oversee the delivery of the IPAC training.

Sources: Surge Learning completion report and staff interviews.
[523]

WRITTEN NOTIFICATION: Security of drug supply

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.

The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including all areas where drugs were stored kept locked at all times when not in use.

Rationale and Summary:
On a specific date during the inspection, Inspector #563 was provided the medication incident reports from the DOC. The DOC took the reports from a folder on their desk. The DOC office door was open and the gate to the reception area before the DOC office was also open and unlocked with no one at reception. There were several observations where the DOC office door was open and unlocked and the reception area was open and unlocked, and unattended during the inspection.

The specific medication incidents and the medication strip packages with medications were attached intact to the reports. Inspector #563 and the DOC reviewed the strip packages attached to the medication incident reports and the DOC verified the medications attached to the incident reports were stored in the DOC office in a folder on their desk and the office door was not locked and the strip packs with drugs were accessible. The DOC verified drugs were not stored in an area that was secure and locked. The DOC office remained open and unlocked and available to anyone who entered the office area that was unmanned on multiple occasions throughout the day for multiple days.

Sources: Medication Incident Reports Exeter Villa Nursing Home, observations of the DOC office and staff interviews.

[563]

WRITTEN NOTIFICATION: Security of drug supply

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 2.

The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including access to these areas shall be restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

Rationale and Summary:
On a specific date during the inspection, Inspector #563 was provided the medication incident reports from the DOC. The DOC took the reports from a folder on their desk. The DOC office door was open and the gate to the reception area before the DOC office was also open and unlocked with no one at reception. There were several observations where the DOC office door was open and unlocked and the reception area open was unlocked and unmanned during the inspection.

The specific medication incidents and the medication strip packages with medications were attached intact to the reports. Inspector #563 and the DOC reviewed the strip packages attached to the medication incident reports and the DOC verified the medications attached to the incident reports were stored in the DOC office in a folder on their desk and the office door was not locked and the strip packs with drugs were accessible to anyone. The DOC verified drugs were not stored in an area that was secure and locked and access to the DOC office was not restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

Sources: Medication Incident Reports Exeter Villa Nursing Home, observation of the DOC office, and staff interviews.
[563]

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 1.

The licensee failed to ensure as part of the medication management system, that a written drug destruction and disposal policy was developed in the home that provided for drugs that were to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that were available for administration to a resident, until the destruction and disposal occurs.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee was required to ensure the TRI MD Pharmacy Disposal of Controlled Medications Policy 6-5 last revised February 21, 2019, was complied with as a part of the Medication Management System in the home. Specifically, the home did not comply with the licensee's TRI MD Pharmacy Disposal of Controlled Medications Policy 6-5 to ensure drugs that were to be destroyed and disposed were stored safely and securely within the home.

Rationale and Summary:
Inspector #563 and #523 entered the medication room escorted by a Registered Practical Nurse (RPN). Inspector #563 was able to physically remove controlled substance cards of medications from the double-locked stationary cupboard through the round port hole on the face of the double locked stationary cupboard and then through the slot at the top. Inspector #563 could have also removed a single medication dose from an individual blister. Administrator verified controlled substances that were to be destroyed and disposed were not stored safely and securely within the home.

TRI MD Pharmacy Disposal of Controlled Medications Policy 6-5 last revised February 21, 2019, stated the home was responsible for compliance with federal and provincial laws and regulations in the handling of controlled medications. The home did not ensure that drugs that were to be destroyed and disposed of were stored safely and securely within the home for controlled substances.

Sources: Observation, TRI MD Pharmacy Disposal of Controlled Medications Policy and staff interviews. [563]

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.

The licensee failed to ensure as part of the medication management system, that a written drug destruction and disposal policy was developed in the home that provided for any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the

destruction and disposal occur.

Rationale and Summary:
TRI MD Pharmacy Disposal of Controlled Medications Policy 6-5 last revised February 21, 2019, stated, "c. The two nurses are then responsible to witness the medication being placed in the Controlled Medication Destruction and Disposal bin until drug destruction takes place." The written drug destruction and disposal policy did not provide for any controlled substance that were to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs.

A Registered Nurse (RN) reviewed the TRI MD Pharmacy Disposal of Controlled Medications Policy 6- 5 and verified the drug destruction and disposal policy did not provide for any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Sources: TRI MD Pharmacy Disposal of Controlled Medications Policy 6-5 and an interview with RN. [563]

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (3) (b)

The licensee failed to ensure that non-controlled drugs were destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care for non-controlled medications.

Ontario Regulation 246/22, s. 148 (6) states, "For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable."

Rationale and Summary:

Specific medication incidents that occurred between certain dates and the medication strip packages with medications were attached intact to the reports. Inspector #563 and the DOC reviewed the strip packages attached to the medication incident reports and the DOC verified the medications attached to the incident reports were not removed from the strip packages for destruction and they were not destroyed according to the legislation for non-controlled drugs. The DOC stated that the home did not denature any non-controlled drugs for destruction.
Inspector #563 and #523 and the DOC proceeded to the medication room where there was a Daniel's steri-cycle container with a mailbox type lid that contained whole medications that were whole.

Inspector #523 demonstrated that medications in the Daniel's container for storage of non-controlled drugs for destruction were intact and not denatured and therefore not destroyed. The Administrator verified that non-controlled drugs were to be denatured and agreed that consumption was not rendered impossible or improbable.

Specific RNs stated the process for drug destruction for non-controlled medications was to place the medications in the Daniel's disposal bin in the medication room by one registered nursing staff member. Both RNs stated they acted alone. A RN stated registered nursing staff have not destroyed non-controlled drugs in a team acting together and the home's policy does not direct this practice to work as a team.

The TRI MD Pharmacy Disposal of Non-Controlled Medications Policy 3-8 documents, "3. The nurse who processes the order to discontinue or dispose of order is responsible for removing the medication from the medication or treatment cart, surplus storage cupboards and refrigerators. 4. Any Non-Controlled medications are removed and placed in the Medication Disposal bin for destruction. 5. Medications for destruction are stored in a secure locked room until the licensed medical waste company picks up the containers." The policy did not include that a drug was considered to be destroyed when it was altered or denatured to such an extent that its consumption was rendered impossible or improbable, or that non-controlled drugs were destroyed by a team acting together.

Sources: the TRI MD Pharmacy Disposal of Non-Controlled Medications Policy 3-8, medication room observations on November 24 and 28, 2022, and staff interviews.
[563]

WRITTEN NOTIFICATION: Orientation

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 3.

The licensee has failed to ensure that no staff at the home would perform their responsibilities before receiving training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. The training required under section 82 of the FLTCA must be provided within one week.

Rationale and Summary:
A specific staff members stated they did not receive training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities. The Surge Learning Education History Report documented the Extendicare Zero Tolerance for Abuse and Neglect was not completed.

The Administrator verified that not all staff hired after April 11, 2022, completed their required training. The education tracking report also showed that staff had not all received their required training.

Sources: The education tracking report dated November 30, 2022, and staff interviews. [563]

WRITTEN NOTIFICATION: Orientation

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 4.

The licensee has failed to ensure that no staff at the home would perform their responsibilities before receiving training in the duty to make mandatory reports. The training required under section 82 of the FLTCA must be provided within one week.

Rationale and Summary:
Specific staff members stated they did not receive training in the duty to make mandatory reports prior to performing their responsibilities.

The Administrator verified that not all staff hired after April 11, 2022, completed their required training. The education tracking report also showed that staff had not all received their required training.

Sources: The Surge Learning Education History Report dated November 30, 2022, and staff interviews. [563]

WRITTEN NOTIFICATION: Orientation

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 9.

The licensee has failed to ensure that no staff at the home would perform their responsibilities before receiving training in infection prevention and control (IPAC). The training required under section 82 of the FLTCA must be provided within one week.

Rationale and Summary:
Specific staff members stated they did not receive training in IPAC prior to performing their responsibilities.

The Administrator verified, and the education tracking report documented that not all new staff hired after April 11, 2022, completed their training related to the IPAC or it was not completed within a week of hire.

Sources: The Surge Learning Education History Report dated November 30, 2022, and staff interviews. [563]