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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
central.west.sao@ontario.ca

Original Public Report

Report Issue Date: October 28, 2022	
Inspection Number: 2022-1340-0001	
Inspection Type: Critical Incident System	
Licensee: Villa Forum	
Long Term Care Home and City: Villa Forum, Mississauga	
Lead Inspector Romela Villaspir (653)	**Inspector Digital Signature** Romela Villaspir Romela Villaspir 2022.10.28 13:38:53 -04'00'
Additional Inspector(s) Parimah Oormazdi (741672) Alicia Campbell (741126) Amanpreet Kaur Malhi (741128) Kristen Owen (741123)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 17-21, 2022.

The following intake(s) were inspected:

- Intake: #00002945 related to missing or unaccounted for controlled substance.
- Intake: #00002392 and Intake: 00005448 related to falls prevention, and management.
- Intake: #00005146 related to an unexpected death of a resident.
- Intake: #00006901 related to an alleged unsafe transfer of a resident.

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

Medication Management
Infection Prevention and Control
Falls Prevention and Management
Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 6 (10) (b)

The licensee has failed to ensure that a resident's current plan of care related to transfers was revised when their care needs changed.

Rationale and Summary
A resident had a fall which resulted in an injury, and a change in their transfer status. When their condition returned to baseline, the plan of care was not updated.

A Registered Practical Nurse (RPN) acknowledged that the resident's plan of care regarding their transfer care needs, was not reviewed and revised.

There was low risk related to the resident's plan of care not being updated, as the staff who were not familiar with the resident may not know what their care needs were.

Sources: Inspector #741128's observation; Critical Incident (CI) report, resident's clinical health records, Resident Care Plans policy #LTC-CA-ON-100-02-17, last revised in May 2017; Interviews with a Personal Support Worker (PSW) and RPN. [741128]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS FOR PROGRAMS

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions were documented.

Rationale and Summary
A resident had an unwitnessed fall that resulted in an injury and being transferred to a hospital.

The resident was at risk for falls, and as per their plan of care they were using a Personal Assistance Service Device (PASD), and were required to be monitored for safety at a specific

time interval. However, this intervention and the resident's response to the intervention had not been documented by staff, which resulted in inconsistent monitoring of the resident, putting them at high risk of fall.

Sources: CI report, resident's clinical health records; Interviews with the Resident Assessment Instrument (RAI)-Minimum Data Set (MDS) Coordinator, PSW, Nurse Manager (NM), and the Director of Care (DOC). [741672]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure a PSW used safe transferring techniques when assisting a resident.

Rationale and Summary
A resident required a specific number of staff to assist them with transfers. On one occasion, the resident was not provided with the required assistance during a transfer. As a result, the resident had a fall and sustained an injury.

Sources: CI report, resident's clinical health records, the home's internal investigation notes; Interviews with a PSW, RPN, and the DOC. [741123]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2

The licensee has failed to comply with strategies to manage a resident's pain post-fall.

Rationale and Summary

According to O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure the pain management program, at minimum, provides for strategies to manage pain for residents, and must be complied with.

The home's falls prevention policy directed staff to complete a pain assessment if a resident was experiencing pain post-fall.

A resident had an unwitnessed fall in their room. During a post-fall assessment, the resident complained of pain, however, a pain assessment was not completed in Point Click Care (PCC) as required. About two hours post-fall, the resident could not weight bear due to pain, and a scheduled pain medication was administered. A comprehensive pain assessment was not initiated, and the resident was subsequently sent to hospital for further assessment, where they were diagnosed with an injury.

A RPN confirmed that pain assessment must be completed to manage the resident's pain effectively. The resident was at increased risk for delayed treatment and ineffective pain management.

Sources: CI report, resident's clinical health records, Falls Prevention policy #LTC-CA-WQ-200-07-08, origination date: February 2007; Interview with a RPN. [741128]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 131 (2)
The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident had a physician's order for a drug to be given by mouth twice a day.

On two subsequent days, the drug was not administered to the resident in accordance with the directions for use specified by the prescriber.

By not ensuring that the resident received their medication as specified by the prescriber, the resident was put at risk for adverse effects.

Sources: Resident's clinical health records; Interviews with an Agency Registered Nurse (RN), Assistant Director of Care (ADOC), and the DOC. [653]

WRITTEN NOTIFICATION: DRUG RECORD (ORDERING AND RECEIVING)

NC #06 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 133

The licensee has failed to ensure that a drug record was maintained, and kept in the home for at least two years, in which the following information was recorded, in respect of every drug that was ordered and received in the home:
1. The date the drug was ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug was ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug was received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.

Rationale and Summary

The home submitted a CI report related to missing/ unaccounted controlled substances.

A) A resident had a physician's order for an as needed pain medication.

A review of the pharmacy statement/ invoice for the resident showed the medication was dispensed by pharmacy on five different dates within a span of two months, at no charge to the resident.

A review of the home's drug record book including the pharmacy medication reorder sheets, showed that the required information in respect of this drug that was ordered and received in the home as specified in the legislation, was not recorded.

According to the home's internal investigation, there were 120 tablets of the resident's as needed pain medication that were missing and unaccounted for.

Sources: Resident's clinical health records, pharmacy statement/ invoice, pharmacy Medication Reorder Sheets, CI report, the home's internal investigations notes; Interviews with Agency RN,

ADOC, and the DOC.

B) A resident had a physician's order for an as needed subcutaneous pain medication.

A review of the pharmacy statement/ invoice for the resident showed the medication was dispensed by pharmacy on 11 different dates within a span of two months, at no charge to the resident.

A review of the home's drug record book including the pharmacy medication reorder sheets, showed that the required information in respect of this drug that was ordered and received in the home as specified in the legislation, was not recorded.

According to the home's internal investigation, there were 161 vials of the as needed subcutaneous pain medication that were missing and unaccounted for.

Sources: Resident's clinical health records, pharmacy statement/ invoice, Drug Record Book, pharmacy Medication Reorder Sheets, CI report, the home's internal investigations notes; Interviews with Agency RNs, ADOC, and the DOC. [653]

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #07 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 135 (1) (a)

The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary

An Agency RPN noted that a resident's morning medication was missing, therefore the medication was not administered. An Agency RN documented that the resident may have received two doses of the morning medication the day before. The resident was in stable condition, and no distress was noted.

The medication incident was not documented on a medication incident form together with a record of the immediate actions taken to assess and maintain the resident's health.

By not completing a medication incident form, the medication error was not followed through according to the home's and pharmacy's policies and procedures.

Sources: Resident's clinical health records, narcotic and controlled drug administration records, the home's medication incident forms; Interviews with Agency RN, ADOC, and the DOC. [653]

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #08 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 135 (1) (b)

The licensee has failed to ensure that a medication incident involving a resident was reported to the DOC, and the pharmacy service provider.

Rationale and Summary

The medication incident referenced in NC #07 was not reported to the DOC, and the pharmacy service provider.

By not reporting the medication incident to the DOC and the pharmacy service provider, the medication error was not followed through according to the home's and pharmacy's policies and procedures.

Sources: Resident's clinical health records, narcotic and controlled drug administration records, the home's medication incident forms; Interviews with an Agency RN, ADOC, and the DOC. [653]

COMPLIANCE ORDER CO #001 MEDICATION MANAGEMENT SYSTEM

NC #09 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

The Inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155

(1) (a)]:

The Licensee has failed to comply with O. Reg. 79/10, s. 114 (3) (a)

The Licensee shall

1. Ensure Registered Staff on the third floor are re-educated on the home's policies in relation to Medication Administration and Narcotics, specific to signing off on the eMAR and the narcotic and controlled drug administration record, following the administration of narcotics; and wasting of unused narcotic in liquid form and in single use ampoule. Maintain records of the re-education provided including the date, content, facilitator, and attendees.
2. Ensure that Registered Staff are signing off on the eMAR and the narcotic and controlled drug administration record, following the administration of narcotics to two specific residents, by completing daily audits during medication administration for a two-week period, or until compliance is achieved. A copy of the audits must be kept in the home.

Grounds

Non-compliance with: O. Reg. 79/10, s. 114 (3) (a)

The licensee has failed to ensure that the home's policies on Medication Administration and Narcotics, were complied with.

Rationale and Summary

The home submitted a CI report related to missing/ unaccounted controlled substances.

According to O. Reg. 79/10, s. 8. (1) (b), 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, is complied with.

O. Reg. 79/10, s. 114 (2) requires the licensee to 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.

O. Reg. 79/10, s. 114 (3) requires the written policies and protocols to be implemented.

A) The home's Medication Administration policy indicated that there is a Medication Administration Record (MAR), which includes date, time, dose, and route, where applicable, signed by the person who gave the medication immediately following the medication administration. After administering the medication to the resident, the registered staff are to return to the medication cart and sign for the administration of each medication given.

i) A resident had a physician's order for an as needed pain medication.

The resident's narcotic and controlled drug administration record showed that the resident received this medication 13 times within a two-month period, which were not documented in the eMAR.

Sources: Resident's clinical health records, narcotic and controlled drug administration records, the home's Medication Administration policy #LTC-CA-WQ-200-06-01 effective date: May 2012, CI report, the home's internal investigations notes; Interviews with an Agency RN, ADOC, and the DOC.

ii) A resident had a physician's order for a pain medication to be given by mouth once daily.

A RN administered the medication to the resident, but did not sign on the eMAR for its administration.

Sources: Resident's clinical health records, narcotic and controlled drug administration records, the home's Medication Administration policy #LTC-CA-WQ-200-06-01 effective date: May 2012, CI report, the home's internal investigations notes; Interviews with an Agency RN, ADOC, and the DOC.

iii) A resident had a physician's order for an as needed subcutaneous pain medication.

The resident's narcotic and controlled drug administration record showed that the resident received this medication 18 times within a two-month period, which were not documented in

the eMAR.

By the registered staff not signing the eMAR for the administration of each medication given, there was a risk for the inaccurate administration of the drugs to the residents. The frequency of administration may not be accurately followed.

Sources: Resident's clinical health records, narcotic and controlled drug administration records, the home's Medication Administration policy #LTC-CA-WQ-200-06-01 effective date: May 2012, CI report, the home's internal investigations notes; Interviews with an Agency RN, ADOC, and the DOC.

B) The home's Narcotics policy indicated that if the narcotic being administered is in a liquid form and is in single use ampoule - if not all of the contents of the ampoule are required for administration, two Registered Staff must witness the wasting of the unused portion of the ampoule. The amount wasted is to be documented on the narcotic count sheet.

A resident had a physician's order for an as needed subcutaneous pain medication.

A RN asked an Agency RPN to sign off on the narcotic and controlled drug administration record to indicate they witnessed the wasting of two vials of the medication, without physically seeing the unused portion of the vial that was wasted.

By not following the home's Narcotics policy, there was a risk for the inaccurate disposal of the drug.

Sources: Resident's clinical health records, narcotic and controlled drug administration records, the home's Narcotics policy #LTC-CA-WQ-200-06-14 last revised in December 2017, CI report, the home's internal investigations notes; Interviews with the ADOC, and DOC. [653]

This order must be complied with by December 8, 2022

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.