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

Ottawa District
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Original Public Report

Report Issue Date: April 29, 2024
Inspection Number: 2024-1183-0001
Inspection Type: Complaint
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
Long Term Care Home and City: The Village Green Nursing Home, Selby

Lead Inspector	**Inspector Digital Signature**
Darlene Murphy (103)	Darlene Murphy Digitally signed by Darlene Murphy Date: 2024.05.02 11:26:28 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 22, 23, 2024.

The following intake(s) were inspected: Intake: #00113485 -complaint related to resident care.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control

Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure a resident's substitute decision-maker was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary:

Staff discovered medications hidden in a resident room. The physician was informed, and medication changes were made in response to this incident. The resident's Power of Attorney (POA) was not advised of the incident involving the medications or the changes made to the resident's medication regime.

The Administrator confirmed the home has a process in place for the notifications of a POA and believed the staff's failure to make the notifications was an oversight.

Failing to ensure the POA is given the opportunity to participate fully in the development and implementation of the resident's plan of care places the resident at risk of improper care.

Sources:
Resident progress notes, interviews with the Administrator.
[103]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure a verbal complaint made regarding the care of a resident was provided a response within 10 business days that complied with the legislative requirements.

Rationale and Summary:
On April 5, 2024, the Administrator met with a resident's Power of Attorney (POA) regarding complaints related to resident care. The Administrator indicated the

issues were investigated, however the home failed to provide the POA with a written response within 10 business days to outline what the licensee had done to resolve the complaint.

Failing to comply with the complaints process potentially leads to unresolved issues and can negatively impact resident care.

Sources:
Complaints policy, "Investigating and Responding to complaints", interview with the Administrator and review of the home's complaint report.
[103]

WRITTEN NOTIFICATION: Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (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 licensee is required to ensure there are written policies and protocols developed for the medication management system to ensure the accurate administration of all drugs used in the home.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure the policies developed for the medication management system are complied with. Specifically, the licensee failed to ensure staff complied with the policy, "The

medication pass", last revised on June 30, 2023, by failing to ensure a resident was ingesting the medications being administered.

Rational and Summary:
Staff found pain medications hidden in a resident room. The home investigated and found the resident was not always ingesting their medications at the time of administration, but holding on to them in case they required them at a different time. Staff members stated the resident had been resistant to having staff watch them take their medications. The resident indicated they were worried they would not be able to get the medication when they needed it for pain.

Staff failing to ensure the resident was taking their medication as prescribed placed this resident and other residents at risk of harm from accidental ingestion/overdose.

Sources:
Policy, "The Medication Pass", review of resident progress notes, interviews with the resident and staff members.
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