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: August 8, 2024
Inspection Number: 2024-1031-0001
Inspection Type: Proactive Compliance Inspection
Licensee: Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation
Long Term Care Home and City: Tilbury Manor Nursing Home, Tilbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 2, 3, 4, 5, 8, 10, 2024
The inspection occurred offsite on the following date(s): July 8, 9, 10, 2024
The following intake(s) were inspected:

- Intake: #00119345 - Proactive Compliance Inspection - 2024

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

Quality Improvement
Residents' Rights and Choices
Pain Management

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)
Non-compliance with: FLTCA, 2021, s. 85 (1)
Posting of information
s. 85 (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

The licensee failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location.

Rationale and Summary
During a tour of the home on July 2, 2024, an information board located on the first floor between the first aid room and the business office was observed. The board contained information for the duty to make mandatory reports and the written procedure and contact information for making complaints to the Director. There was a flyer with the title "Resident & Family Information" indicating that the information and policies of the Long-Term Care Home were located in the Public Document

Binder located at the first floor nursing station. The flyer contained a list of these policies which included the policy to promote zero tolerance of abuse and neglect of residents and whistle-blowing protection.

During an interview with staff who confirmed that the binder referred to on the information board was unable to be located. The required information was therefore not easily accessible.

On July 10, 2024, it was observed that a new binder with the required information was created and placed at the first floor nursing desk/reception desk. The binder also contained the resident council meeting minutes. The information that is required to be posted was now in a conspicuous and easily accessible location.

Sources: Observations and interviews with staff

[000751]

Date Remedy Implemented: July 10, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that two windows in the home that open to the

outdoors and are accessible to residents cannot be opened more than 15 centimetres.

Rationale and Summary
During observations on July 2, 2024, related to the windows in the home, the windows were measured to open more than 15 centimetres.

An email communication on July 9, 2024, from staff confirmed that the maintenance staff had looked at the windows and fixed them to not open more than 15 centimetres.

During observations on July 10, 2024, the windows were locked and unable to be opened.

Sources: Observations, email communication with Administrator

[000751]

Date Remedy Implemented: July 10, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

In accordance with O.Reg 246/22 s. 138 (1) (b) The licensee has failed to ensure that

controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Rationale and Summary
Specifically, during an observation on July 5, 2024, of the home's medication room on the second floor there was no double lock system in place where the locked pharmacy bin was stored in a stationary cupboard.

Staff confirmed on July 5, 2024, that the stationary pharmacy box located on the second floor was not double locked as there were no locks on the cupboard where the locked box is stored. Staff stated there would be a second locking device installed on the cupboard where the pharmacy box is located on the second floor.

On July 8, 2024, inspector observed a lock had been installed on the cupboard doors where the locked stationary pharmacy bin was located on the second floor of the home.

There was a low risk and low impact to the residents as the medication room on the second floor was locked.
Sources: Observations of the medication storage room on the second floor, and interview with DOC #100.

[000750]

Date Remedy Implemented: July 8, 2024

WRITTEN NOTIFICATION: Air Temperature

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 1.
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.

The licensee failed to ensure that the air temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

Summary and Rationale:
During an interview with the home's maintenance staff, they stated that they measured and documented the temperature of the home once a day, in the morning, and that the temperature reading was taken at the nurse's desk on each floor.

Staff acknowledged that the home was not measuring and documenting air temperatures in at least two resident bedrooms in different parts of the home.

Not recording and documenting air temperatures in at least two resident bedrooms in different parts of the home put residents at risk of not being comfortable in their room.

Sources: Source Water Temperature Log, Hot Weather-Related Plan, Interviews with maintenance staff and the Administrator.

[739]

WRITTEN NOTIFICATION: Air Temperature

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 2.
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.

The licensee failed to ensure that the air temperature was measured and documented in writing in one resident common area on every floor of the home.

Summary and Rationale:
The home's hot weather-related plan, revised April 3, 2024, indicated in part that, the Nurse Manager/Environmental Services Manager/delegate was to ensure that the temperature and humidity was measured each day throughout the year at a minimum in one resident common area on every floor of the home.

The staff acknowledged that the home was not measuring and documenting air temperatures in one resident common area on every floor of the home.

Not recording and documenting air temperatures in one resident common area on every floor of the home put residents at risk of not being comfortable in their home.

Sources: Source Water Temperature Log, Hot Weather-Related Plan, Interviews with maintenance staff and the Administrator.

[739]

WRITTEN NOTIFICATION: Menu Planning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (c) (i)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(c) is approved for nutritional adequacy by a registered dietitian who is a member of the staff of the home, and who must take into consideration,
(i) subsection (1),

Rationale and Summary
In accordance with O. Reg 246/22 s. 77 (2) (c) (i), the licensee has failed to ensure that, prior to being in effect, each menu cycle, is approved for nutritional adequacy by a registered dietitian who is a member of the staff of the home, and who must take into consideration, O. Reg 246/22 s. 77 subsection (1).

Specifically, on July 2, 2024, during an interview with the dietary staff, who confirmed that they had independently created the posted menu for July 1-7, 2024, and had not reviewed the July 1-7, 2024, menu with a registered dietician (RD) prior to posting the menu. Dietary staff, confirmed during interview on July 2, 2024, that the resident's diet, their choice, or restrictions were not taken into consideration when they created the menu for July 1-7, 2024.

During an interview on July 2, 2024, with dietary staff, who confirmed the same

three-week meal cycle had been cooked and served to residents living in the home since October 2023. Dietary staff acknowledged that the menu did have substitutions throughout the time from October 2023-July 2, 2024, that were not reviewed with the RD prior to being implemented, posted, and served to the residents. Dietary staff confirmed menu substitutions were related to food supply inventory and not resident choice.

Inspector interviewed Registered Dieticians (RD), on July 4, 2024, who both confirmed they did not review the posted menu for the week of July 1-7, 2024, prior to the menu being posted.

Record review from the homes Food Committee meetings that took place on March 7, 2023, April 4, 2023, May 2, 2023, June 6, 2023, September 12, 2023, November 7, 2023, December 5, 2023, January 11, 2024, February 6, 2024, April 9, 2024, and June 11,2024, had documented that the residents had requested a variety of fresh foods be offered with the meals, and change as the residents stated their frustrations regarding the menu being repetitive.

Observations of both first and second floor dining rooms on July 2,3,4,5, 2024, indicated meals being served were from the posted menu July 1-7, 2024.

On July 3, 2024, during an interview with a resident, who confirmed they were unable to have dessert on July 2, 2024, and have had to skip meals because the meals offered contained only items that they were unable to eat related to their dietary restrictions and were not provided with any alternative choices on those days. Residents confirmed during interviews on July 3, 2024, that the menu has been the same since the fall of 2023, and that they have shared their choices for menu items with the staff in the home on several occasions.

There was a low risk to the residents residing in the home as the posted menu for July 1-7, 2024, had not been reviewed by the homes RD prior to being implemented and posted, and the menu did not include resident choices.

Sources: Posted menu July 1-7, 2024, meal observations, staff interviews, and resident interviews.

[000750]

WRITTEN NOTIFICATION: Menu Planning

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)
Menu planning
s. 77 (3) The licensee shall ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented. O. Reg. 246/22, s. 390 (1).

Rationale and Summary
In accordance with O. Reg 246/22 s. 77 (3), the licensee has failed to ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented O. Reg 246/22, s. 390 (1).

Specifically, on July 2, 2024, dietary staff confirmed the staff had been discarding the weekly posted menus after that menu had ended. Dietary staff both confirmed during interview on July 2, 2024, that the home had not been keeping any of the

written menu cycle evaluations.

On July 9, 2024, staff confirmed the home had no written records of the menu cycle evaluations.

During observations of the home's kitchen on July 2, 2024, there were no previous menus located from the past weeks or months observed in the kitchen area.

There was a low risk to residents as the home had not been keeping a written record of the menu cycle and evaluations.

Sources: Observations of the kitchen and interviews with staff members..

[000750]

WRITTEN NOTIFICATION: Food Production

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions.

Rationale and Summary

In accordance with O. Reg 246/22 s. 78 (2) (f), the licensee has failed to ensure that the food production system, at a minimum, provide communication to residents and staff of any menu substitutions.

Specifically, during observations on July 2, 2024, of both the first and second floor dining rooms the posted weekly menu was observed posted on a multipurpose corkboard in the dining rooms on a back wall directly in front of where a table of residents sit. The posted menu was observed to be at the top of the corkboard and other scattered documents were posted near the menu, no visible changes to the menu were observed. After residents had finished their breakfasts, on July 3, 2024, inspector observed the posted weekly menus in both the first and second floors dining rooms and had observed that there had been no visible changes to either posted menus. After lunch had been served on July 3, 2024, inspector observed the posted menus on both the first floor and second floors dining rooms had been altered and had blue ink used to scratch out one of the lunch meal choices of pulled pork on a bun, coleslaw, and peaches, and instead in writing on both the menus in each dining room was observed to have been substituted with chicken strips, fries, and salad.

Residents confirmed during interviews on July 2, 2024, and July 3, 2024, that the paper size that the posted weekly menu was on was not visible to them because of the small print size and the location of the menus in each of the dining rooms.

During interviews with residents all confirmed that they had never been made aware of any menu changes including substitutions prior to eating their meals.

During interviews with dietary staff, on July 2, 2024, both confirmed that there are many substitutions made to the posted menu, and often staff will not update the posted menus or update other staff or residents of the meal substitutions. Both dietary staff, acknowledged and confirmed the posted menu for July 1-7, 2024, had

a substitution made to it on July 3, 2024, and dietary staff had updated the posted menus after the meal had been served to residents.

There was a low risk to residents as the menu substitutions were not communicated to residents or staff prior to the meal being served.

Sources: Observations on both the first and second floors dining rooms posted weekly menus, interviews with residents and staff.

[000750]

WRITTEN NOTIFICATION: Food Production

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (4) (c)
Food production
s. 78 (4) The licensee shall maintain, and keep for at least one year, a record of,
(c) menu substitutions. O. Reg. 246/22, s. 78 (4).

Rationale and Summary

In accordance with O. Reg 246/22, s. 78 (4) (c), the licensee has failed to maintain, and keep for at least one year, a record of, menu substitutions.

Specifically, during observations on July 2, 2024, on both the first and second floor dining rooms the posted weekly menu was observed to have had no visible changes to the menu. On July 3, 2024, inspector observed both the first and second floor dining rooms posted menus and had observed that there had been no visible changes to either posted menus. After lunch had been served on July 3, 2024, inspector observed the posted menus on both the first floor and second floor dining rooms and observed the posted menus had blue ink used to scratch out the lunch meal choice of pulled pork on a bun, coleslaw, and instead the handwritten substitution for that meal was chicken strips, fries, and salad.

During interviews with dietary staff, on July 2, 2024, who both confirmed that there had been many substitutions made to the posted menu cycles for the past several months including the posted menu for July 1-7, 2024. Dietary staff, both confirmed that the home had not been keeping records of any substitutions made to the menus as staff discard the posted weekly menus into the garbage at the end of each week.

During an interview with staff, on July 8, 2024, who confirmed the home had not been keeping records of the posted menus and substitutions for the year.

There was a low risk to residents as the menu and substitutions were not kept recorded for one year.

Sources: Observations of both first and second floor dining rooms posted weekly

menus, interviews with the Administrator, and dietary staff #106, and #107

[000750]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

Rationale and Summary
In accordance with the O. Reg 246/22 s. 79 (1) 5, the Licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, food and fluids being served at a temperature that is both safe and palatable to the residents. Specifically, on July 2, 2024, inspector reviewed the food temperature log binder in the kitchen of the home for the months of January, February, March, April, May, June, and July 2024, and observed all of the temperature log sheets had been missing information on them that included the date, month, year, and the daily food temperature readings for each meal had missing recordings for all puree, and minced meals. The regular diet food temperature logs sheets were inconsistently recorded as the months reviewed had missing multiple meal recordings for all three meals each day and other temperature log sheets reviewed had one of the three meals recorded regular diet temperature only as the rest of the recordings were

blank.

The food temperature binder log sheets were reviewed on July 2, 3, 4, 5, 2024, and during those days the temperature log sheets had no dates and times recorded on it. Inspector observed the food temperature log sheets on July 2, 2024, were separated in the binder by a monthly tab divider, and each log sheet was for one week of that month and the food log sheets were sectioned off for temperature recordings to be recorded for each breakfast, lunch, and supper, meal that included regular, minced and pureed diet temperatures, then below those sections were headings for vegetables, gravies, and starches, which inspector observed all food log sheets for all the months reviewed had blank weekly pages, and other sheets had blank sections under each day, each meal, and some months had only one week of inconsistent and incomplete recorded temperatures.

During interviews with dietary staff on July 2, 2024, who both confirmed that the expectation for the dietary staff were to record the temperatures of the food at each meal and record the information onto the food temperature log sheet right away prior to serving each meal to the residents. Both dietary staff acknowledged and confirmed on July 2, 2024, that the food temperature log sheets had not been completed for the months of January, February, March, April, May, June, and July 2024.

Staff confirmed on July 9, 2024, that they were unaware that the food temperature logs had not been completed daily with each meal as expected.

Interviews with residents on July 3, 2024, who both confirmed that they had each received meals on several occasions and most recently on July 2, 2024. that were not safe and palatable.

There were risks to the residents as food temperatures were not being recorded which resulted in residents being served meals that were not safe and palatable on multiple occasions.

Sources: Food log temperature binder, interviews with staff and residents.

[000750]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (1)
Continuous quality improvement committee
s. 166 (1) Every licensee of a long-term care home shall establish a continuous quality improvement committee.

The licensee has failed to establish a continuous quality improvement committee.

Rationale and Summary
Staff acknowledged that there was no continuous quality improvement committee established in the home.

Failure to not have a continuous quality improvement committee was a missed opportunity for the licensee to the implement the continuous quality improvement initiative.

Sources: Record review of quarterly professional advisory/quality improvement committee report and interview with staff.

[000751]

COMPLIANCE ORDER CO #001 Menu planning

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (b)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(b) is evaluated by, at a minimum, the nutrition manager and registered dietitian who are members of the staff of the home;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

A) The DOC or designate will complete once weekly audits to ensure that the weekly posted menu including substitutions have been reviewed by the home's Registered Dietician (RD) and Nutritional Manager (NM). All audits will continue until an inspector has complied the order.

B) Audits will include the name of the person completing the audits, date and time of the audits, RD name, nutritional manager name, and the date and time of when the RD and NM reviewed the weekly posted menu including the substitutions. The audits will include all recommendations, any concerns identified, and corrective actions taken as a result of the audits.

Grounds

Rationale and Summary

In accordance with O. Reg 246/22 s. 77 (2) (b), the licensee was required to ensure that, prior to being in effect, each menu cycle, is evaluated by, at a minimum, the nutritional manager and registered dietician who are members of the staff of the home.

Specifically, on July 2, 2024, during an interview with dietary staff, who confirmed they had independently created the posted menu for July 1-7, 2024, and had not reviewed the July 1-7, 2024, menu with the Registered Dietitian (RD) or Nutrition Manager (NM) prior to being posted, nor did they know the dietary restrictions for the residents when they created the menu. Dietary staff both confirmed during interviews on July 2, 2024, that the same fall-winter menu containing the same three-week cycle schedule had been in place since October 2023, which resulted in the residents being offered the same foods for the past eight months.

Inspector interviewed RD's on July 4, 2024, who both confirmed they did not review the posted menu for the week of July 1-7, 2024, prior to the menu being posted, and both were unaware that the same three-week cycle of menu's had been in place since October 2023.
Observations of both first and second floor dining rooms on July 2,3,4,5, 2024, indicated meals being served to the residents were from the posted menu July 1-7, 2024.

On July 3, 2024, during an interview with a resident who confirmed they were unable to have dessert on July 2, 2024, and have had to skip meals because the menu contained only items, that they were unable to eat related to their dietary restrictions and there were no alternative choices provided to the resident on those

days. Residents confirmed during interview on July 3, 2024, that the menu has been the same since the fall of 2023.

There was a moderate risk to the residents as the posted menu for July 1-7, 2024, had not been reviewed by the homes RD or NM prior to being implemented and posted, and the menu cycle had not been reviewed by a RD or changed since October 2023.

Sources: Posted menu July 1-7, 2024, meal observations, staff and resident interviews.

[000750]

This order must be complied with by August 29, 2024

COMPLIANCE ORDER CO #002 Dining and snack service

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 6.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Sufficient time for every resident to eat at their own pace.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 79 (1) 6. [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:
A) The written plan must outline how the home will offer all residents sufficient time to eat dinner at their own pace. The plan will include revised actions or additional

interventions that will be implemented to provide all residents sufficient time to eat dinner at their own pace.
B) Maintain a documented record of the preparation for the compliance plan, including the dates the preparation took place and name(s) with designation(s) of the person(s) responsible
C) Implement the actions outlined in the written plan by the Compliance Due Date
D) Maintain a documented record of the actions implemented, the dates of implementation and the name(s) with designation(s) of the person(s) responsible

Grounds
Rationale and Summary
In accordance with the O. Reg 246/22 s. 79 (1) 6, the licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, sufficient time for every resident to eat at their own pace.

Specifically, on July 4, 2024, inspector observed the dinner meal at 1700 hours on the first floor and observed approximately twenty residents had been sitting at their tables in the dining room. Inspector observed on July 4, 2024, that the first-floor dining room had at times four staff in the dining room, one staff taking orders from the residents, another staff providing drinks to the residents, and the other two staff were continuing to bring residents in the dining room as many residents required assistance with ambulation and several other residents were observed to be sitting in wheelchairs and staff were pushing those residents into the dining room. Inspector remained observing the first-floor dining room on July 4, 2024, until 17:15 hours, as no residents had yet received their meals, while some residents had received a beverage. Other staff were observed transporting residents into the dining room and were taking food orders from the residents.

Inspector then observed dining on the second floor at 17:17 hours on July 4, 2024,

and observed one resident sitting in a wheelchair at the nursing desk and approximately twenty-two residents were observed sitting at their tables in the dining room. Inspector observed a few residents had received their dinner meals, and others were being served their beverages, while other staff were taking orders from the residents, another staff member was observed taking meals into residents' rooms to drop off and then was observed moments later back in the dining room as they were then picking up another meal to be delivered to another resident's room. At 17:45 hours inspector returned to the first-floor dining room on July 4, 2024, and observed five residents were sitting in the dining room at their tables, no dinner plates were observed on the tables.

During interviews with residents on July 3, 2024, both confirmed they felt rushed to eat their dinner meals quickly as staff have told them they had to clean up before 1800 hours. Both residents confirmed they don't feel rushed when eating their breakfast or lunch meals daily, however felt rushed at each dinner meal.

During interviews with staff, who both acknowledged that they had witnessed staff were rushing residents to eat dinner.

Record review of the food committee meeting that had occurred on April 9, 2024, had documented concerns from some residents that had reported that the staff seemed to be in a hurry when taking residents orders.

There is a moderate risk to residents as they are not provided sufficient time to eat their dinner meals at their own paces daily.

Sources
Interviews with staff, dining observations of all three meals on both the first and second floors, record review of the food committee minutes from April 9, 2024, also

interviews with residents.

[000750]

This order must be complied with by August 29, 2024

COMPLIANCE ORDER CO #003 Drug destruction and disposal

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is 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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Safe storage of drugs
1) The home will install a double-locked stationary cupboard and storage container for the safe storage of controlled substances that is to be located in a separate locked room on the first floor.
2) Registered staff who work on the first floor are to receive a tour of the locked room where the double locked stationary cupboard is located and provided instruction on the medication policy regarding the destruction and disposal of

controlled medications.
3) The Director of Care (DOC) or delegate will keep a written signed copy of the registered staff names that includes the signatures of each registered staff, the dates the registered staff received their tour and update on the safe storage for the controlled substances located on the first floor of the home. This information will be made available to the inspector upon request.

Grounds
Rationale and Summary
In accordance with O. Reg s. 148 (2) (2), the licensee has failed to ensure that controlled substances that are to be destroyed and disposed of on the first floor 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

Specifically, on July 5, 2024, staff confirmed the homes medication policies and procedures in place and that they had access to these documents when needed.

Inspector observed the locked storage room on the first floor with registered staff on July 5, 2024, and noted sharps containers on the floor and white pharmacy pail on the floor, which registered staff had confirmed are the two places registered staff dispose of the controlled medications on the first floor.

Policy #7.7 titled Narcotic and Controlled medications stated in section three that medication removed for destruction is documented by two staff and transferred immediately to the double locked one-way disposal box. The section four in policy #7.7 stated that if the one-way access disposal box dedicated for disposal of narcotic medications is not located on the same unit/floor, the two nurse transport the narcotic and controlled medication together deposit the medication in the one-

way access disposal box.

There was a moderate risk to the residents as the medications were stored in a locked storage room separate from where the medications being administered are kept.

Sources
Policy #7.7 Destruction and disposal of narcotic and controlled medications, interviews with registered staff, observations of medication storage room on the first floor.

[000750]

This order must be complied with by August 29, 2024

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

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.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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:

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

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

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.