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: April 3, 2024

Inspection Number: 2024-1598-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: Corporation of the County of Elgin

Long Term Care Home and City: Bobier Villa, Dutton

Lead Inspector	**Inspector Digital Signature**
Melanie Northey (563)	Melanie Northey Digitally signed by Melanie Northey Date: 2024.04.05 10:49:12 -04'00'

Additional Inspector(s)
Brandy MacEachern (000752)
Pauline Waldon (741071)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
March 6, 7, 8, 11, 12, 13, 14 and 15, 2024

Inspector Neelam Patel (000814) was present.

The following intake(s) were inspected:

- Intake: #00109697 - Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and 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: O. Reg. 246/22, s. 79 (1) 1.
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:
1. Communication of the seven-day and daily menus to residents.

The licensee has failed to ensure that the home had a dining and snack service that included communication of the seven-day menu to residents.

Rationale and Summary
The seven-day menu cycle was observed posted outside the dining rooms, however the cycle ended three days prior. The Manager of Support Services (MSS) verified that the seven-day menu was posted for communication to residents for all three week cycles outside each dining room, however the dates were not changed using the dry erase marker to indicate the repeated cycle for the next three weeks. The MSS was responsible for updating the menu cycle calendar dates and the communication of the seven-day menu cycle should have been updated. The seven-day menu cycle was updated.

The menu cycle for the residents was not communicated and residents were not provided with advanced notice and time to make meal choices.

Sources: observations, and resident and staff interviews. [563]

Date Remedy Implemented: March 12, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection Prevention and Control Program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

Rationale and Summary
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). 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."

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

One wall mounted container of Aloe Care ABHR had an expiry date of 2022 and was located at the doors between the dining room areas. The Administrator was in the dining room and was made aware of the expired hand sanitizer and it was replaced immediately. No resident or staff member was observed using the ABHR at any time before or during the lunch service. There were no other expired products for hand hygiene observed during the course of the inspection. The Administrator verified hand hygiene products should be within their expiry date.

Sources: IPAC Standard for Long-Term Care Homes, observations and staff interviews. [563]

Date Remedy Implemented: March 6, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (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 licensee failed to ensure that any controlled substance that was to be destroyed and disposed of was 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.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee was required to ensure the Long Term-Care (LTC) Narcotics and Controlled Substances Policy was complied with as a part of the Medication Management Program to ensure drugs that were to be destroyed and disposed were stored safely and securely within the home.

Rationale and Summary
The home's Medication-Destruction of Narcotics & Controlled Drugs policy documented all discontinued narcotics and controlled drugs were monitored to ensure accurate and safe destruction according to home, Pharmacy policy and procedure, and applicable legislation.

Controlled substances for destruction were stored in a locked stationary cupboard in the medication room, however the cupboard was overfilled and the drugs were accessible. Registered Practical Nurses (RPN) were present when Inspector easily removed several cards of controlled substances from the storage area. The interim MRC verified the controlled drugs for destruction were not stored safely and securely within the home. The storage area was not observed accessible to residents or anyone else other than the registered staff who had key access to the

medication room which was locked at all times. Only the MRC has key access to the locked stationary cupboard in the medication room designated for discontinued narcotics and controlled drugs.

Interim MRC and the RPN completed reconciliation of the controlled substances for destruction, counting the drugs and validating against the resident individual controlled substance and narcotic count sheets to determine there were no missing controlled substances. The interim MRC followed up with the staff by email and contacted pharmacy to implement a process or other intervention to prevent reoccurrence related to the removal of controlled substances for destruction from the designated storage area in the medication room. There was potential risk for missing or unaccounted controlled substances.

Sources: Medication-Destruction of Narcotics & Controlled Drugs policy and other relevant documentation, observations and staff interviews. [563]

Date Remedy Implemented: March 11, 2024

WRITTEN NOTIFICATION: Duty to Respond

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to respond to concerns and recommendations of the Residents' Council and Food Committee within 10 days in writing.

Rationale and Summary

During the inspection of the Resident's Council, it was identified that concerns and recommendations had been brought forward at council meetings regarding care, and food.

The Manager of Support Services advised that they verbally followed up to the food concerns and recommendations, but the written follow up was included in the meeting minutes which was distributed to the residents at the following monthly meeting.

The Administrator informed that care concerns brought forward at the Resident's Council meeting were investigated internally, all residents involved in the concern were addressed verbally, and the Administrator attended the following monthly meeting to follow up with the council. Although, there was no written record of a response provided to the Resident's Council within 10 days of the care concerns raised at the meeting.

There was a risk that members of the Resident's Council would not have been aware of the actions taken to resolve the concerns brought forward at the meetings, when written responses were not provided within 10 days.

Sources: Staff interviews, Residents' Council meeting minutes, Food Committee meeting minutes, Residents' Council binder, Food Committee binder. [000752]

WRITTEN NOTIFICATION: General Requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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 those changes were implemented.

The licensee has failed to ensure the written record of the pain management program, the skin and wound care program, and the falls prevent and management program evaluations included documentation of the summary of the changes made and the date that those changes were implemented.

Rationale and Summary
A) The Pain Management and Palliative Care Program 2022- 2023 evaluation was completed July 2023, and there was a written record of the evaluation that included goals to achieve the purpose, indicators to monitor, results against targets, and strategies to improve results; however, there was no analysis of the summary of the changes made and the date that those changes were implemented documented as part of the evaluation. The analysis and summary of evaluation was added by the Interim Manager of Resident Care (Quality Improvement Coordinator for Elgin Homes) during the inspection, after discussion with Inspector #563.

The MRC verified the “Analysis and summary of changes made in 2022-2023” were not documented as part of the evaluation evaluated on July 3, 2023 with the participants listed, and the information was added during the inspection, after a conversation with the inspector. The program evaluations and the analysis and

summary of changes made in 2022-2023 were a part of the continuous quality improvement (CQI) documentation at the Professional Advisory Committee (PAC) meeting in December 2023, but not added to the written record of the annual evaluation for the pain program.

There was risk when the home did not appropriately evaluate the required programs to determine if the programs were effective in managing pain for residents. [563]

B) The Skin and Wound Care Program 2022- 2023 evaluation was completed September 2023, and there was a written record of the evaluation that included goals to achieve the purpose, indicators to monitor, results against targets, and strategies to improve results; however, there was no analysis of the summary of the changes made and the date that those changes were implemented documented as part of the evaluation. The analysis and summary of evaluation was added by the Interim Manager of Resident Care (Quality Improvement Coordinator for Elgin Homes) during the inspection, after discussion with Inspector #563.

The interim MRC verified the “Analysis and summary of changes made in 2022-2023” were not documented as part of the evaluation evaluated in September 2023 with the participants listed, and the information was added during the inspection, after a conversation with Inspector #563. The program evaluations and the analysis and summary of changes made in 2022-2023 were a part of the CQI documentation at the PAC meeting in December 2023, but not added to the written record of the annual evaluation for the skin and wound care program.

There was risk when the home did not appropriately evaluate the required programs to determine if the programs were effective in managing pain for residents. [000752]

C) The Falls Prevention Program 2022- 2023 evaluation was completed April 2023, and there was a written record of the evaluation that included goals to achieve the purpose, indicators to monitor, results against targets, and strategies to improve results; however, the "Change(s) or New Strategies to Improve Results: Results of Changes/Actions Reviewed" section of the evaluation did not include the dates that those changes were implemented.

The interim MRC verified the "summary of review" was not documented as part of the evaluation evaluated in April 2023, with the participants listed, and the information was added during the inspection, after a conversation with Inspector #563. The program evaluations and the analysis and summary of changes made in 2022-2023 were a part of the CQI documentation at the PAC meeting in December 2023, but not added to the written record of the annual evaluation for the fall prevention program.

There was risk when the home did not appropriately evaluate the required programs to determine if the programs were effective in preventing and managing falls for residents. [563]

Sources: Fall prevention program evaluation April 2022- April 2023, pain management program evaluation July 2022- July 2023 and the skin and wound care program evaluation September 2022- September 2023; and interview with the interim Manager of Resident Care.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #006 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.

The licensee has failed to ensure that the home had a dining and snack service that included food and fluids being served at a temperature that was both safe and palatable to residents.

Rationale and Summary
The food temperature logs for the lunch service were requested and the Infection Prevention and Control (IPAC) Manager provided the kitchen production sheets and verified the food temperatures were documented as part of the kitchen production sheets for each meal in each dining room and should be completed according to the home's policy. IPAC Lead validated that the food temperatures were not documented on for the lunch service and should have been. The production sheets for breakfast and dinner on the day and the breakfast service the next day were also reviewed, and the documentation of food temperatures was incomplete.

The Meal Service Policy documented meal service does not begin until the food has been tasted and food temperatures have been taken and recorded and any necessary corrective action has been taken. Appropriate safe food and beverage serving temperatures were to be maintained throughout meal service.

The Food Service Temperatures Policy documented designated Dietary staff in the production area take food temperatures when cooking, chilling, hot-holding or reheating all food products. A Food Temperatures Recording Chart was also to be

completed for all hot menu items prior to meal service (at the point of service).

The Manager of Support Services (MSS) verified that food temperatures had incomplete documentation as part of the Kitchen Production Reports and stated food temperatures should be taken at the time the food was fully cooked in the kitchen, and at the holding temperature in each dining room servery. There was potential risk that food and fluids were not being served at a temperature that was both safe and palatable to the residents.

Sources: Meal Service Policy, Food Service Temperatures Policy, Kitchen Production Reports, and staff interviews. [563]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.
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:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee has failed to ensure course by course service of meals, unless otherwise indicated by the resident or by the resident's assessed needs.

Rationale and Summary
Dietary staff served dessert to residents immediately after serving the main course at lunch. Most residents had just started or were still eating their main course. One resident stopped their meal and ate their dessert. A Registered Nurse and the Support Services Manager stated the expectation was that meals were served

course by course and that residents should have finished their main course and the plate cleared, before serving dessert.

The Meal Service Policy documented soiled dishes were to be removed between courses as able and foods were to be served course by course, unless contraindicated in the residents' plan of care. There was risk that some residents might not have eaten their meal if dessert was served before they had finished their entre.

Sources: Meal Service Policy 2.18. observations and staff interviews. [563]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control.

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

Rationale and Summary
A) IPAC Standard for Long-Term Care Homes April 2022 and last revised September 2023, documented an additional requirement under The Standard in section 10.2 where the hand hygiene program shall ensure that the program included, at minimum, hand hygiene and hand care support for residents. The licensee was also to ensure that the hand hygiene program for residents had a resident-centered approach with options for residents, while ensuring that hand

hygiene was being adhered to. The hand hygiene program for residents was to include assistance to residents to perform hand hygiene before meals and snacks.

Hand sanitizer wipes were available on random tables, wall mounted Alcohol-Based Hand Rub (ABHR) hand sanitizer and portable containers of hand sanitizer all with 70 percent (%) ethyl alcohol were available for use. A sign was posted outside the dining room that stated, "please remember to sanitize all residents' hands when entering and exiting the dining room" with wall mounted Purell ABHR available.

During the lunch service on two separate dates, staff were not observed providing hand hygiene cueing or assistance to residents entering or exiting the dining room before the meal. Inspector #563 observed the medication administration for a resident, who was then portered to the dining room by a Personal Support Worker (PSW) who did not stop at the door to the dining room to ensure resident hand hygiene was encouraged or provided before their meal service and hand sanitizer wipes were not provided. Staff were bringing other residents into the dining room without completing hand hygiene, and for those residents who entered dining room independently did so without hand hygiene and without verbal staff prompting to perform hand hygiene.

The Registered Practical Nurse (RPN) verified resident hand hygiene was to be done prior to meals and after, although there were times hand hygiene was missed after meals if the residents left the dining room. A number of infectious diseases can be spread from one person to another by contaminated hands, putting residents at risk. [563]

B) The licensee has failed to ensure the implementation of any standard or protocol issued by the Director with respect to infection prevention and control.

Section 9.1 (b) of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes states, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include hand hygiene, including, but not limited to, the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

A staff member was observed portering a resident to their room, enter the room of a second resident, take a used wash cloth from the first resident and put it in the laundry, assist the second resident after they stood up from their wheelchair in the hallway, get a third resident's walker from the dining room, give a fourth resident a wash cloth in the dining room, clean the wash basin and leave the dining room, all without performing hand hygiene.

Another staff member was observed to touch a resident's back and then deliver drinks to other residents without performing hand hygiene. Inspector also observed another staff member stand up from a resident's table and cough into their upper arm. This staff member then exited the dining room, coughed on the back of their hand, took a drink of water, and re-entered the dining room, where they sat back down at the table and fed a resident without performing hand hygiene.

The failure of staff to follow the four moments of hand hygiene, puts residents at risk for the transmission of disease-causing or infectious organisms. [741071]

Sources: Observations, IPAC Standard for Long-Term Care Homes (September 2023), observations and staff interviews.

WRITTEN NOTIFICATION: IPAC Program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (c)
Infection Prevention and Control Program (IPAC)
s. 102 (4) The licensee shall ensure,
(c) that the interdisciplinary infection prevention and control team meets at least quarterly and on a more frequent basis during an infectious disease outbreak in the home.

The Licensee has failed to ensure that an interdisciplinary infection prevention and control (IPAC) team meets at least quarterly.

Rationale and Summary
The IPAC Manager reported that the home did not have an interdisciplinary IPAC committee that meets quarterly as required, and reported that they planned to implement a formal IPAC committee in the home by June 1, 2024.

Not ensuring an interdisciplinary IPAC team meets at least quarterly, may impact how IPAC measures were managed in the home.

Sources: Interview with the IPAC Manager, and review of the Program Manager of IPAC Job Description (JD Code: LTC-012-2022, June 2022). [741071]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2)
Medication incidents and adverse drug reactions

s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b).

The licensee failed to ensure that every medication incident involving a resident was documented, reviewed and analyzed, corrective action was taken as necessary; and a written record was kept of everything including a documented record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary
Progress notes documented a resident was found with multiple doses of a specific type of medication in their room.

The interim Manager of Resident care (MRC) verified multiple doses of a specific type of medication in a resident's room did not know where the medication came from so a medication incident report was not completed. The Interim MRC also stated they could not rule out that the resident was hiding the medication provided by the nurse. The MRC verified it was not safe to assume the resident brought the pills with them from home on admission, especially when there was documentation where the resident told staff they had extra medication in their room several months ago.

There was no analysis of the possible multiple omissions of the medication, no corrective action to prevent reoccurrence, and the potential risk was identified with no documentation of follow up or reassessment, and there would be no quarterly analysis of the incident to prevent a possible adverse drug reaction when the resident had access to multiple doses in their room. The undocumented medication incident

was not appropriately reviewed and analyzed so that corrective action was taken, and there was risk that the incident would then not be included as part of the next quarterly review undertaken of all medication incidents to reduce and prevent similar medication incidents from occurring.

The Interim MRC verified it was a medication incident involving a resident and it was not documented, it was not reviewed and analyzed, corrective action was not taken as necessary; and a written record was not kept of everything including a documented record of the immediate actions taken to assess and maintain the resident's health.

Sources: resident clinical record review, and staff interviews. [563]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2)
Continuous Quality Improvement Initiative Report
s. 168 (2) The report required under subsection (1) must contain the following information:
1. The name and position of the designated lead for the continuous quality improvement initiative.
2. A written description of the home's priority areas for quality improvement, objectives, policies, procedures and protocols for the continuous quality improvement initiative for the next fiscal year.
3. A written description of the process used to identify the home's priority areas for quality improvement for the next fiscal year and how the home's priority areas for quality improvement for the next fiscal year are based on the recommendations of the home's continuous quality improvement committee.

4. A written description of a process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement in the next fiscal year.

5. A written record of,

i. the date the survey required under section 43 of the Act was taken during the fiscal year,

ii. the results of the survey taken during the fiscal year under section 43 of the Act, and

iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

6. A written record of,

i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,

iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and

v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that their Continuous Quality Improvement (CQI)

initiative report met each of the requirements of Ontario Regulation (O. Reg) 246/22, s. 168 (2).

Rationale and Summary
The Quality Improvement plans posted to the home's website for the 2023/2024 fiscal year did not fulfill the requirements of O. Reg. 246/22, s. 168 (2). Quality Improvement (QI) Lead was unable to clearly demonstrate how the report posted on the home's website met each requirement under O. Reg 246/22, s. 168 (2).

There was a risk that all requirements were not addressed or followed up on when the home did not include all of the required QI sections of the report.

Sources: Bobier Villa QIP Progress Report 2023/2024, Bober Villa QIP Narrative 2023/2024, Bobier Villa QIP Work plan 2023/2024, Interviews with the QI Lead. [000752]

WRITTEN NOTIFICATION: Quality Improvement Initiative Report

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous Quality Improvement Initiative Report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that a copy of the Continuous Quality Improvement (CQI) Initiative Report was provided to the Residents' Council and Family Council.

Rationale and Summary

The home's Quality Improvement (QI) report was posted on their website for 2023/2024, and there was no documentation of the report distributed to the Residents' Council or Family Council. The Manager of Program and Therapy Services and the Family Council Assistant identified that the QI report was not shared at Residents' Council or Family Council.

There was a risk that members of the Resident's Council and Family Council would not be aware of the information included in this report.

Sources: Bobier Villa QIP Progress Report 2023/2024, Bober Villa QIP Narrative 2023/2024, Bobier Villa QIP Work plan 2023/2024, Interviews with the Manager of Program and Therapy Services and Family Council Assistant. [000752]

COMPLIANCE ORDER CO #001 Administration of Drugs

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 140 (7)

Administration of Drugs

s. 140 (7) Where a resident of the home may administer a drug to themself under subsection (6), the licensee shall ensure that there are written policies to ensure that the residents who do so understand,

(a) the use of the drug;

(b) the need for the drug;

(c) the need for monitoring and documentation of the use of the drug; and

(d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on their person or in their room under subsection (8).

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. 246/22, s. 140 (7)
Specifically, the licensee must:
a) Review and revise, as needed, the home's policy related to medication self-administration and all associated appendices. A documented record of the review and/or revision, the date of the review, the changes made if any, and who participated must be maintained.
b) Ensure the nursing management team, registered nursing staff, and physicians are trained on the home's policy/procedure/process related to medication self-administration. A documented record must be maintained of the training; including the date the training was provided, content covered as part of the training, and the names of the identified staff who participated.
c) Ensure the home's policy related to medication self-administration is complied with for the resident.
d) Ensure the resident is evaluated for safe self-administration of medications and the resident is informed of the evaluation results and care plan strategies to ensure safe medication administration.
e) Ensure the plan of care for the resident is updated to include interventions related to safe medication administration and monitoring, if required.
f) Ensure a medication incident report is documented for the omitted medication doses or the resident and ensure the incident is reviewed and analyzed and corrective action is taken as necessary.

Grounds
The licensee failed to ensure that the home's Self-Administration of Medications policy was complied with for the resident.

Ontario Regulation 246/22, s. 11 (1) (b) states where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

Rationale and Summary
Progress notes documented a resident was found with multiple doses of a specific type of medication in their room.

The interim Manager of Resident care (MRC) verified multiple doses of a specific type of medication in a resident's room did not know where the medication came from so a medication incident report was not completed. The Interim MRC also stated they could not rule out that the resident was hiding the medication provided by the nurse. The MRC verified it was not safe to assume the resident brought the pills with them from home on admission, especially when there was documentation where the resident told staff they had extra medication in their room several months ago.

An Evaluation For Self-Administration of Medications was completed for the resident. The evaluation documented self-administration by the resident was for a specific medication pass only and identified the resident had the ability to recognize each of the medications, a knowledge of what the medications were for and the correct times to take each medication, had sufficient knowledge of any precautions or adverse effects explained by the nurse or physician, had the ability to anticipate when the medication needs reordering, and understood that those medications must be protected from access by other persons. There was no other Evaluation For Self-Administration of Medications completed as part of the paper clinical record.

There was a physician's order for the resident to have medications for self-administration. The medication administration record identified the resident was

administered all doses of the medication in a specific month and there were no refusals documented. It was unclear when the resident omitted the administration of the multiple doses of medication over several months to reconcile the doses found in their room. There was no direction as part of the plan of care to ensure the resident took their medication as ordered.

The Medication-Self Administration by a Resident policy documented:

- The nurse will document on the resident's care plan and the progress notes the resident's capability of self-administering medication/treatments including a description of any required assistance.
- The nurse must ensure that medications/treatments left for self-administration are kept in a secure, locked, place to prevent misuse by other residents; taken/used by the resident as intended and not discarded or accidentally taken by another resident.
- The nurse will do on-going assessments (quarterly and as required with significant change in status) of the resident's capacity to self-administer his/her medications/treatments and will document this in the progress notes.
- The resident's competency to self medicate must be regularly reassessed (every three months) utilizing the "Evaluation for Self-administration of Medications" form. If the resident was deemed competent for self-administration, the physician will re-order the direction for medication self-administration as part of the quarterly medication review.

Registered nursing staff did not reassess the resident's ability to self-administer bedtime medications when the resident was found to have multiple doses of a medication found in their room, putting the resident and other residents at risk. The medications were to be kept in a secure, locked, place to prevent misuse by other residents, and the medication was not taken by the resident as intended, rather

accumulated. Accumulating medications presents possible risk of overdose, and the care plan and medication administration record did not have any direction for nursing staff to ensure the resident was not accumulating medications in their room. The MRC stated there should have been a new evaluation of the resident to self-administer and the plan of care should have been updated when there was a change in the resident's ability to self-administer safely.

Sources: Medication-Self Administration by a Resident Policy, resident clinical record review, and staff interviews. [563]

This order must be complied with by May 3, 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.