Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 19, 2015	2015_217137_0040	024284-15	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

THE VILLAGE OF GLENDALE CROSSING
3030 Singleton Avenue LONDON ON N6L 0B6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MARIAN MACDONALD (137), DONNA TIERNEY (569), HELENE DESABRAIS (615), RAE MARTIN (515)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 9-11 and 14-17, 2015.

During the Resident Quality Inspection, concurrent inspections were also completed:
Critical Incident System Log # 015403-15 related to staff to resident abuse; Two Critical Incident Inspections Log # 018822-15 and Log # 024038-15 related to resident to resident abuse; Three Complaints Log # 016980-15, Log # 021891-15 and Log # 023711 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with General Manager, Director of Nursing, Director of Food Services, Director of Environmental Services, Assistant Director of Nursing, Registered Dietitian, two Resident Assessment Instrument/Quality Improvement (RAI/QI)Nurses, three Neighbourhood Coordinators, one Administrative Assistant, one Maintenance Staff, one Registered Nurse, 11 Registered Practical Nurses, 17 Personal Support Workers/Personal Care Providers, one Dietary Aide, one Housekeeper, four Family Members and 40+ Residents.

The Inspectors also toured all resident neighbourhoods, common areas, medication storage areas, observed dining service, care provision, resident/staff interactions, recreational programs, medication administration, reviewed residents' clinical records, relevant policies and procedures, staff education records and various meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **6 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) 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,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on December 18, 2014, under Log # 009192-15 and Inspection # 2014_263524_0044.

A written notification of non-compliance and a voluntary plan of correction were previously issued on November 24, 2014, under Log # L-001536-14 and Inspection # 2014_216144_0063.

A written notification of non-compliance and a voluntary plan of correction were previously issued on October 2, 2014, under Log # 004625-14 and Inspection # 2014_303563_0037.

A written notification of non-compliance was previously issued on August 1, 2013, under Log #'s L-000584-13 and L-000531_13 and Inspection # 2013_229213_0022.

A written notification of non-compliance and a voluntary plan of correction were previously issued on July 2, 2013, under Log # L-000333-13 and Inspection # 2013_183135_0027.

A written notification of non-compliance and a Compliance Order were previously issued on April 23, 2013, under Log # L-000146-13 and Inspection # 2013_186171_0017.

A written notification of non-compliance was previously issued on April 23, 2013, under Log # L-000216-13 and Inspection # 2013_090172_0016.

A written notification of non-compliance and a Compliance Order were previously issued on February 5, 2013, under Log # L-000077-13 and Inspection # 2013_186171_0005.

A written notification of non-compliance and a Compliance Order were previously issued on December 7, 2012, under Log # L-001815-12 and Inspection # 2012_183135_0020.

The areas of non-compliance issued were related to several policies not being complied with, including Falls Prevention and Management.

A review of the home's "Fall Prevention & Management" Policy, dated February 2013, indicated that "If the Resident hits their head or there were no witnesses to the fall, the

Head Injury Routine is followed".

A review of the home's "Head Injury Routine Policy", dated January 2013, indicated that "In the event of an unwitnessed fall, where the Resident is unable to confirm whether there was a trauma to the head, the head injury routine is to be followed as a precautionary measure."

A review of the clinical health care record, for an identified resident, revealed the resident had five unwitnessed falls and there was no documented evidence that the head injury routine was completed, as per the home's policy.

During an interview with the RAI coordinator, it was confirmed that all unwitnessed falls should be assessed, be followed up for 24 hours and a head injury routine be initiated.

During an interview with the Director of Care, it was confirmed that the current policy on Falls Prevention & Management requires a head injury routine to be initiated for unwitnessed falls and that staff did not comply with the home's policy. [s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A review of the "Head Injury Routine Policy", dated January 2013, directed staff that "in the event of an unwitnessed fall, where the resident was unable to confirm whether there was trauma to the head, the head injury routine was to be followed as a precautionary measure".

A review of the clinical health care record, for an identified resident, revealed that the resident sustained two unwitnessed falls. There was no documented evidence that the resident was assessed for head injury following the falls.

This observation was confirmed by the RAI Coordinator.

The General Manager confirmed the expectation that in the event of an unwitnessed fall, where the resident was unable to confirm whether there was trauma to the head, the head injury routine would be completed by staff and that the policy would be complied with. [s. 8. (1) (b)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted was complied with, related to the Medication Management System.

A) A review of the Home's policy #3.6 - "Medication Refrigerators", effective date September 1, 2013, revealed the procedure "directed staff that each medication refrigerator must be kept clean and free of non-medication items".

On September 15 and 16, 2015, medication refrigerators were observed, on all six Neighbourhoods, and the following deficiencies were identified:
- 5/6 (83%) of the refrigerators were visibly soiled with dried spillage on the bottom of the fridge and the shelves of the door.
- 4/6 (66.6%) of the refrigerators had thick ice build up in the freezer compartment.

The observations were confirmed by the registered staff on each of the Neighbourhoods. The staff acknowledged that the medication refrigerators were to be cleaned by the registered staff on the night shift.

B) A review of the Home's policy #3.9 - "Emergency Stock Box", effective date September 1, 2013, revealed the procedure indicated that "the Home would monitor the inventory and expiry dates on a monthly basis and reorder any medications that were missing or have expired by faxing the reorder label to Pharmacy".

On September 15, 2015, expired medications were observed in the Emergency Drug Box on Westminster Neighbourhood as follows:
- Salbutamol 1/1 (100%) expired February 2015
- Epipen 1/1 (100%) expired February 2015
- Epinephrine vials 2/2 (100%) expired March 2015
- Diphenhydramine vials 3/5 (60%) expired May 2015
- Tobradex eye drops 1/1 (100%) expired August 2015

The observations were confirmed by a Registered Nurse.

C) A review of the Home's policy #4.9 - "Narcotic and Controlled Medication Documentation", effective date September 1, 2013, documented the following:
"During each shift change, the outgoing and oncoming Registered Staff will count all narcotics and sign on the Shift Change Narcotic Controlled Drug Count Record.
Any count or documentation discrepancies noted on the Resident Count Card or Shift Change/Narcotic/Controlled Drug Count Record must be brought to the Director of Care's attention immediately".

A review of the Controlled Drug Count from August 6 - September 14, 2015, identified the following deficiencies:
August 11-15, 2015, 4/15 shifts (26.6%) were missing the second initials of a registered staff.
August 16-20, 2015, on August 20, 2015, the drug count did not accurately reflect the destruction of controlled medications and the Director of Nursing did not initial the drug destruction.
August 21-25, 2015, 1/15 shifts (0.6%) missing the second initials of a registered staff.
August 26-30, 2015, 3/15 shifts (20%) missing the second initials of a registered staff and 3/15 shifts (20%) there was no documented drug count.
August 31-September 4, 2015, on September 3, 2015, the drug count did not accurately reflect the destruction of controlled medications and the Director of Nursing did not initial the drug destruction.
September 5-9, 2015, 4/15 shifts (26.6%) missing the second initials of a registered staff.
Sept 10-14, 2015, 1/15 shifts (0.6%) missing the second initials of a registered staff.

The observations were confirmed by the Director of Nursing and a Registered Nurse.

D) A review of the Home's policy # 8.1 - "Non-Controlled Medication Destruction", effective date September 1, 2013, and revised August 1, 2014, identified the following:

"All medications to be destroyed will be prepared for disposal by removing any excess packaging and placing medications in the Drug Destruction Container which is supplied by the Pharmacy or a designated medical waste disposal company.
The Drug Destruction Container is located in the medication room or other secure area only accessible by the nurse. These medications are to be kept separate from medications available for administration to a resident.
Once the Drug Destruction Container is full, medications are destroyed with the addition of soapy water which would render the contents impossible or improbable to be reused. The container is then sealed and set aside for the removal by a designated waste disposal company. Once the medications have been destroyed and the disposal container is sealed, the disposal container no longer needs to be kept in the medication room".

On September 16, 2015, two pails full of discarded medications were observed in the government stock room. The pails were open and drugs were noted to be in strip packaging, plastic medication cups and loosely in the pails. The drugs were not

denatured and were accessible to all members of the leadership team. Within the leadership team, 6/11 (54.4%) are non registered staff.

The observations were confirmed by the Director of Nursing who acknowledged that the policy was not complied with.

An interview with the Director of Nursing and General Manager confirmed that the expectation was that staff comply with the policies of the home. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(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. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. A written notification of non-compliance was previously issued on February 5, 2013, under Log # L-000077-13 and Inspection # 2013_186171_0005, related to the safe storage of drugs.

The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

A jar of physician prescribed topical cream was observed on the bedside table of an identified resident.

There was no documented evidence of a physician's order to leave the prescription cream at bedside and the prescription cream should have been discontinued.

The Director of Nursing confirmed the prescription cream was not to be left at the bedside, was to be kept locked and secure.

A medication cart was observed unlocked and unattended, in the hallway near an identified Neighbourhood Dining Room.
A registered staff member was seated at the dining room table administering medications to a resident and the registered staff member had his/her back to the medication cart.

The registered staff member confirmed that the medication cart was left unlocked and unattended, as well as the expectation that the medication cart should be within visual proximity at all times when in use. [s. 129. (1) (a) (ii)]

2. The licensee has failed to ensure that drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs.

Observation of the medication room on the Westminster Neighbourhood identified the following deficiencies:

Medication Cupboard
a) One bottle of Senekot caplets expired November 2014, and two bottles expired August 2015.
b) Two bottles of Potassium Chloride liquid expired November 2014.
c) One bottle of Ferrous Gluconate tablets expired December 2014.
d) A prescription medication for Scopolamine for an identified resident expired May 2015.

Emergency Drug Box
a) One Epipen expired February 2015.
b) One ampule of Salbutamol expired February 2015.
c) One vial of Epinephrine expired March 2015.

d) Three vials of Diphenhydramine expired May 2015.
e) One bottle of Tobradex eye drops expired August 2015.
The observations were confirmed by a Registered Staff member.

Observation of the government stock room identified the following deficiencies:

a) One bottles of sterile Saline expired in August 2014 and one bottle expired in May 2015.
b) Three bottles of sterile Water expired in July 2015.
c) Bottles of Novasen tablets due to expire in December 2015 observed to be discarded in the Stericycle pail
The observations were confirmed by the Director of Nursing.

An interview with the Neighbourhood Coordinator, responsible for ordering and managing the government stock room, acknowledged that discarded medication had not yet expired.

The Director of Nursing and the General Manager both confirmed the expectation that drugs stored in the home would comply with the manufacturer's instructions for the storage of the drugs. [s. 129. (1) (a) (iv)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on February 5, 2013, under Log # L-000077-13 and Inspection # 2013_186171_0005.

A written notification of non-compliance and a Compliance Order were previously issued on December 7, 2012, under Log # L-001815-12 and Inspection # 2012_183135_0020.

The areas of non-compliance issued were related to the plans of care not setting out clear directions to staff and others who provide direct care to the residents.

The licensee has failed to ensure that the plan of care, for an identified resident, set out clear directions to staff and others who provide direct care to the resident.

A review of the electronic and paper health care records, for an identified resident, revealed there was a specific intervention in place to manage continence.

A review of the care plan revealed no documented evidence of caring for the intervention.

During an interview with the RAI coordinator, it was confirmed that caring for the intervention was not in the care plan and that the Home's expectation was to have it in the care plan.

During an interview with the Director of Care, it was confirmed that it was the Home's expectation that individual interventions be in the resident's care plan, related to continence care. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plans of care set out clear directions to staff and others who provide direct care to the residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Observations, during the initial tour and throughout the Resident Quality Inspection (RQI), revealed identified deficiencies such as damaged and paint chipped doors, door frames, walls, ceiling tiles, wooden side tables and wooden chair legs, in all Neighbourhood Home Areas.

During a tour and interview, with the Director of Environmental Services, the identified deficiencies were confirmed, as well as the expectation that the home, furnishings and equipment were to be maintained in a safe condition and good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on December 7, 2012, under Log # L-001815-12 and Inspection # 2012_183135_0020, related to post fall assessments not being completed.

The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of the clinical health care record, for an identified resident, revealed the resident sustained an unwitnessed fall.

There was no documented evidence that a post falls assessment was completed. In an interview, the RAI Coordinator confirmed a post-fall assessment was not completed.

The General Manager confirmed the home's expectation that when a resident has fallen, the resident was assessed and a post falls assessment was completed. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

On September 9, 2015, the laundry room door was observed to be open, on the Westminster Neighbourhood. A 20 litre container of Alpine Green Choice Laundry Detergent, with biohazard labels indicating poisonous and corrosive chemicals and labels indicating "Keep away from children" and "Do not take internally", was inside a cupboard and accessible to residents.

A registered staff member confirmed that hazardous substances were present and tried to lock the cupboard. The latch was bent and the staff member was unable to lock the cupboard.

The Director of Nursing repaired the latch on the door, locked the cupboard and confirmed the home's expectation was that hazardous substances were to be kept inaccessible to residents at all times. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including restricting access to those areas to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

An interview with the Director of Nursing revealed that government stock medications were stored in a secure area within the locked General Storage and Boiler Room.

During a tour of the Government Stock storage area, on September 16, 2015, one non registered leadership team member was observed in the secure area.

The Director of Nursing, Assistant Director of Nursing and the General Manager acknowledged that all members of the leadership team have access to the medication supply. Within the leadership team, 6/11 (54.5%) are non registered staff.

The Director of Nursing and the General Manager confirmed the home's expectation was that all areas where drugs were stored would be restricted to persons in accordance with the legislation. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to ensure the security of the drug supply, including restricting access to those areas to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption was rendered impossible or improbable.

On September 16, 2015, during a tour of the government stock area, individual pills, capsules, medication in strip packaging and injectible medications were observed to be discarded in two Stericycle pails. The drugs were not denatured and were accessible to registered and non-registered staff, who had keys to the room.

The observation was confirmed by the Director of Nursing who also acknowledged, that the practice in the home was that non controlled medications are not denatured prior to disposal.

The Director of Nursing confirmed the expectation that drug destruction would be done in accordance with the legislation. [s. 136. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home of every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home.

During an interview, an identified resident revealed that a sum of money had gone missing from his/her bedroom several months ago. The resident shared that the incident had been reported.

During an interview, with a Neighbourhood Co-ordinator, it was revealed that he/she was not aware of this complaint.
A review of the huddle notes revealed documentation of missing money but did not specify the amount or whose money was missing.

A review of the home's incident binder, Section 3 Resident/Family Concerns for 2014 and 2015, revealed there was no documented evidence of this complaint.

An interview, with the General Manager on September 15, 2015, revealed she was aware of the missing money and it's dollar value for the identified resident. The General Manager was unable to locate any documentation record of this complaint and confirmed a Resident/Family Concern Response Form should have been completed. [s. 101. (2)]

Issued on this 19th day of October, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIAN MACDONALD (137), DONNA TIERNEY (569), HELENE DESABRAIS (615), RAE MARTIN (515)
Inspection No. / No de l'inspection :	2015_217137_0040
Log No. / Registre no:	024284-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 19, 2015
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF GLENDALE CROSSING 3030 Singleton Avenue, LONDON, ON, N6L-0B6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MICHELLE VERMEEREN

To Schlegel Villages Inc, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) 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,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must take action to achieve compliance by ensuring that the plan, policy, protocol, procedure, strategy or system, is complied with, specifically related to Falls Prevention and Management, Medication Refrigerators, Emergency Drug Box, Narcotic and Controlled Medication Documentation and Non-Controlled Medication Destruction.

Grounds / Motifs :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on December 18, 2014, under Log # 009192-15 and Inspection # 2014_263524_0044.

A written notification of non-compliance and a voluntary plan of correction were previously issued on November 24, 2014, under Log # L-001536-14 and Inspection # 2014_216144_0063.

A written notification of non-compliance and a voluntary plan of correction were previously issued on October 2, 2014, under Log # 004625-14 and Inspection # 2014_303563_0037.

A written notification of non-compliance was previously issued on August 1, 2013, under Log #'s L-000584-13 and L-000531_13 and Inspection # 2013_229213_0022.

A written notification of non-compliance and a voluntary plan of correction were previously issued on July 2, 2013, under Log # L-000333-13 and Inspection # 2013_183135_0027.

A written notification of non-compliance and a Compliance Order were previously issued on April 23, 2013, under Log # L-000146-13 and Inspection # 2013_186171_0017.

A written notification of non-compliance was previously issued on April 23, 2013, under Log # L-000216-13 and Inspection # 2013_090172_0016.

A written notification of non-compliance and a Compliance Order were previously issued on February 5, 2013, under Log # L-000077-13 and Inspection # 2013_186171_0005.

A written notification of non-compliance and a Compliance Order were previously issued on December 7, 2012, under Log # L-001815-12 and Inspection # 2012_183135_0020.

The areas of non-compliance issued were related to several policies not being complied with, including Falls Prevention and Management.

The licensee has failed to ensure that the home's policy on "Fall Prevention and Management" was complied with.

A review of the home's "Fall Prevention and Management" Policy, dated February 2013, indicated that "If the Resident hits their head or there were no witnesses to the fall, the Head Injury Routine is followed".

A review of the home's "Head Injury Routine" Policy, dated January 2013, indicates that "In the event of an unwitnessed fall, where the Resident was unable to confirm whether there was a trauma to the head, the head injury routine was to be followed as a precautionary measure."

A review of the clinical health care record, for an identified resident, revealed the resident had five unwitnessed falls and there was no documented evidence that head injury routine was completed, as per the home's policy.

During an interview with the RAI coordinator, it was confirmed that all

unwitnessed falls would be assessed, be followed up for 24 hours and a head injury routine be initiated.

During an interview with the Director of Care, it was confirmed that the current policy on Falls Prevention and Management required a head injury routine to be initiated for unwitnessed falls and that staff did not comply with the home's policy. (615)

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, related to the Head Injury Routine.

A review of the "Head Injury Routine" Policy, dated January 2013, directed staff that "in the event of an unwitnessed fall, where the resident was unable to confirm whether there was trauma to the head, the head injury routine was to be followed as a precautionary measure".

A review of the clinical health care record, for an identified resident, revealed that the resident sustained two unwitnessed falls. There was no documented evidence that the resident was assessed for head injury following the falls.

This observation was confirmed by the RAI Coordinator.

The General Manager confirmed the expectation that in the event of an unwitnessed fall, where the resident was unable to confirm whether there was trauma to the head, the head injury routine would be completed by staff and that the policy would be complied with. (515)

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted was complied with, related to the Medication Management System.

A) A review of the Home's policy # 3.6 - "Medication Refrigerators", effective date September 1, 2013, revealed the procedure "directed staff that each medication refrigerator must be kept clean and free of non-medication items".

On September 15 and 16, 2015, medication refrigerators were observed on all six Neighbourhoods and the following deficiencies were identified:
- 5/6 (83%) of the refrigerators were visibly soiled with dried spillage on the

bottom of the fridge and the shelves of the door.
- 4/6 (66.6%) of the refrigerators had thick ice build up in the freezer compartment.

The observations were confirmed by the registered staff on each of the Neighbourhoods. The staff acknowledged that the medication refrigerators were to be cleaned by the registered staff on the night shift.

B) A review of the Home's policy # 3.9 - "Emergency Stock Box", effective date September 1, 2013, revealed the procedure indicated that "the Home would monitor the inventory and expiry dates on a monthly basis and reorder any medications that were missing or had expired by faxing the reorder label to Pharmacy".

On September 15, 2015, expired medications were observed in the Emergency Drug Box on Westminster Neighbourhood as follows:
- Salbutamol 1/1 (100%) expired February 2015
- Epipen 1/1 (100%) expired February 2015
- Epinephrine vials 2/2 (100%) expired March 2015
- Diphenhydramine vials 3/5 (60%) expired May 2015
- Tobradex eye drops 1/1 (100%) expired August 2015

The observations were confirmed by a Registered Nurse.

C) A review of the Home's policy # 4.9 - "Narcotic and Controlled Medication Documentation", effective date September 1, 2013, identified the following:
"During each shift change, the outgoing and oncoming Registered Staff will count all narcotics and sign on the Shift Change Narcotic Controlled Drug Count Record.
Any count or documentation discrepancies noted on the Resident Count Card or Shift Change/Narcotic/Controlled Drug Count Record must be brought to the Director of Care's attention immediately".

A review of the Controlled Drug Count from August 6 - September 14, 2015, identified the following deficiencies:
August 11-15, 2015, 4/15 shifts (26.6%) were missing the second initials of a registered staff.
August 16-20, 2015, on August 20, 2015, the drug count did not accurately reflect the destruction of controlled medications and the Director of Nursing did

not initial the drug destruction.
August 21-25, 2015, 1/15 shifts (0.6%) were missing the second initials of a registered staff.
August 26-30, 2015, 3/15 shifts (20%) were missing the second initials of a registered staff and 3/15 shifts (20%) there was no documented drug count.
August 31-September 4, 2015, on September 3, 2015, the drug count did not accurately reflect the destruction of controlled medications and the Director of Nursing did not initial the drug destruction.
September 5-9, 2015, 4/15 shifts (26.6%) were missing the second initials of a registered staff.
Sept 10-14, 2015, 1/15 shifts (0.6%) were missing the second initials of a registered staff.

The observations were confirmed by the Director of Nursing and a Registered Nurse.

D) A review of the Home's policy # 8.1 - "Non-Controlled Medication Destruction", effective date September 1, 2013, and revised August 1, 2014, identified the following:

"All medications to be destroyed will be prepared for disposal by removing any excess packaging and placing medications in the Drug Destruction Container which is supplied by the Pharmacy or a designated medical waste disposal company.
The Drug Destruction Container is located in the medication room or other secure area only accessible by the nurse. These medications are kept separate from medications available for administration to a resident.
Once the Drug Destruction Container is full, medications are to be destroyed with the addition of soapy water which would render the contents impossible or improbable to be reused. The container is then sealed and set aside for the removal by a designated waste disposal company. Once the medications have been destroyed and the disposal container is sealed, the disposal container no longer needs to be kept in the medication room".

On September 16, 2015, two pails full of discarded medications were observed in the government stock room. The pails were open and drugs were noted to be in strip packaging, plastic medication cups and loosely in the pails. The drugs were not denatured and were accessible to all members of the leadership team. Within the Leadership Team, 6/11 (54.4%) are non registered staff.

The observations were confirmed by the Director of Nursing who acknowledged that the policy was not complied with.

An interview with the Director of Nursing and General Manager confirmed that the expectation was that staff comply with the policies of the home.

The scope of this identified non-compliance is widespread, there is previous history of non-compliance and the severity is determined to be a level two, minimal harm or potential for actual harm, as several policies were not complied with, which could negatively impact the residents' health, safety and well being.

(515)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 27, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(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. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee must take action to achieve compliance by ensuring that drugs are stored in an area or a medication cart, that is secure and locked and that complies with manufacturer's instructions for the storage of the drugs.

Grounds / Motifs :

1. A written notification of non-compliance was previously issued on February 5, 2013, under Log # L-000077-13 and Inspection # 2013_186171_0005, related to the safe storage of drugs.

The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On September 9, 2015, at 1240 hours, a jar of physician prescribed topical cream was observed on the bedside table of an identified.

There was no documented evidence of a physician's order to leave the prescription cream at bedside.

and the prescription cream should have been discontinued.

The Director of Nursing confirmed the prescription cream was not to be left at the bedside, was to be kept locked and secured and removed the cream.

A medication cart was observed unlocked and unattended, in the hallway near an identified Neighbourhood dining room.
A registered staff member was seated at the dining room table administering medications to a resident and the registered staff member had his/her back to the medication cart.

The registered staff member confirmed that the medication cart was left unlocked and unattended, as well as the expectation that the medication cart should be within visual proximity at all times when in use. (137)

2. The licensee has failed to ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs.

Observation of the medication room on the Westminster Neighbourhood identified the following deficiencies:

Medication Cupboard
a) One bottle of Senekot caplets expired November 2014, and two bottles expired August 2015.
b) Two bottles of Potassium Chloride liquid expired November 2014.
c) One bottle of Ferrous Gluconate tablets expired December 2014.
d) A prescription medication for Scopolamine for an identified resident expired May 2015.

Emergency Drug Box
a) One Epipen expired February 2015.
b) One ampule of Salbutamol expired February 2015.
c) One vial of Epinephrine expired March 2015.
d) Three vials of Diphenhydramine expired May 2015.
e) One bottle of Tobradex eye drops expired August 2015.
The observations were confirmed by a registered staff member.

Observation of the government stock room identified the following deficiencies:

a) One bottle of sterile Saline expired in August 2014 and one bottle expired in May 2015.
b) Three bottles of sterile Water expired in July 2015.
c) Bottles of Novasen tablets due to expire in December 2015 observed to be discarded in the Stericycle pail
The observations were confirmed by the Director of Nursing.

An interview with the Neighbourhood Coordinator, responsible for ordering and managing the government stock room, acknowledged that discarded medication had not yet expired.

The Director of Nursing and the General Manager both confirmed the expectation that drugs stored in the home would comply with the manufacturer's instructions for the storage of the drugs.

The scope of this identified non-compliance is widespread, there is history of non-compliance and the severity level is determined to be two, minimal harm or potential for actual harm, as this could negatively impact the residents' health, safety and well being. (515)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 27, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARIAN MACDONALD

Service Area Office /
Bureau régional de services : London Service Area Office