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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 9, 2018	2018_262630_0004	012992-16, 013262-16, 033839-16, 034425-16, 005230-17, 007416-17, 008994-17, 009025-17, 010241-17, 014455-17, 014795-17, 016725-17, 016860-17, 016971-17, 019291-17, 020021-17, 020894-17, 021492-17, 021493-17, 021494-17, 021504-17, 021787-17, 023008-17, 023565-17, 027916-17, 029582-17	Critical Incident System

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

AMIE GIBBS-WARD (630), ADAM CANN (634), HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 15, 16, 17, 18, 22, 23, 24, 25, 26, 29, 30 and 31, 2018.

The following Critical Incident intakes were completed within this inspection:

Related to prevention of abuse and neglect:
Critical Incident Log #007416-17 / CI 2979-000032-17;
Critical Incident Log #010241-17 / CI 2979-000046-17;
Critical Incident Log #016725-17 / CI 2979-000071-17;
Critical Incident Log #016860-17 / CI 2979-000072-17;
Critical Incident Log #016971-17 / CI 2979-000073-17;
Critical Incident Log #019291-17 / CI 2979-000081-17;
Critical Incident Log #020894-17 / CI 2979-000084-17;
Critical Incident Log #021492-17 / CI 2979-000089-17;
Critical Incident Log #021493-17 / CI 2979-000090-17;
Critical Incident Log #021494-17 / CI 2979-000091-17;
Critical Incident Log #021504-17 / CI 2979-000092-17.

Related to prevention of abuse and neglect and responsive behaviours:
Critical Incident Log #013262-16 / CI 2979-000026-16;
Critical Incident Log #033839-16 / CI 2979-000091-16;
Critical Incident Log #034425-16 / CI 2979-000094-16;
Critical Incident Log #005230-17/ CI 2979-000019-17;
Critical Incident Log #009025-17 / CI 2979-000042-17;
Critical Incident Log #014795-17 / CI 2979-000067-17;
Critical Incident Log #020021-17 / CI 2979-000083-17;
Critical Incident Log #023743-17 / CI 2979-000098-17.

Related to falls prevention:
Critical Incident Log #023008-17 / CI 2979-000097-17;
Critical Incident Log #023565-17 / CI 2979-000100-17;
Critical Incident Log #027916-17 / CI 2979-000105-17.

Related to medication administration:
Critical Incident Log #012992-16 / CI 2979-000022-16;

Critical Incident Log #008994-17 / CI 2979-000041-17;
Critical Incident Log #014455-17 / CI 2979-000063-17;
Critical Incident Log #021787-17 / CI 2979-000095-17;
Critical Incident Log #029582-17 / CI 2979-000106-17.

The following Complaint intakes were completed at the same time as this inspection and can be found in a separate report (Complaint Inspection #2018_262630_0002):
Complaint Log #012954-17 / IL-51485-LO related to personal support and nursing services;
Complaint Log #013239-17 / IL-51541-LO related to sufficient staffing, personal support services and safe and secure home;
Complaint Log #015502-17 / IL-51848-LO related to personal support services and medication administration;
Complaint Log #022544-17 / IL-53071-LO related to personal support services;
Complaint Log #027833-17 / IL-54400-LO related to personal support services;
Complaint Log #007156-17 / IL-50226-LO related to personal support services and medication administration;
Complaint Log #008595-17 / IL-50593-LO related to personal support services;
Complaint Log #012079-17 / IL-51373-LO related to personal support and nursing services;
Complaint Log #008010-17 / IL-50436-LO related to personal support and nursing services;
Complaint Log #023024-17 / IL-53226-LO related to personal support and nursing services;
Complaint Log #022795-17 / Mandatory Report from Patient Ombudsman related to sufficient staffing and staff to abuse or neglect;
Complaint Log #026044-17 / IL-54090-LO related to staff to resident abuse;
Complaint Log #026379-17 / IL-54142-LO related to staff to resident abuse;
Complaint Log #021623-17 / IL-52832-LO related to staff to resident neglect and skin and wound care;
Complaint Log #012851-17 / IL-51469-LO related to skin and wound care, personal support and nursing services, hospitalization and change of condition and medication administration;
Complaint Log #022561-17 / IL-53044-LO related to personal support services, housekeeping services and sufficient staffing;
Complaint Log #014695-17 / IL-51729-LO related to sufficient staffing;
Complaint Log #022021-17 / IL-52936-LO related to sufficient staffing.

The following Critical Incident intakes were completed at the same time as this inspection and can be found in a separate report (Complaint Inspection #2018_262630_0002):
Critical Incident Log #023743-17 / CI 2979-000098-17 related to staff to resident abuse;
Critical Incident Log #025247-17 / CI 2979-000102-17 related to staff to resident neglect.

The following Follow-up intakes were inspected at the same time as this inspection and can be found in a separate report (Follow-up report # 2018_262630_0003):
Follow-up Log #009124 for Compliance Order (CO) #001 from Complaint Inspection #2017_538144_0009 related to skin and wound care;
Follow-up Log #023013-17 for CO #001 from Resident Quality Inspection #2017_607523_0007 related to prevention of abuse and neglect;
Follow-up Log #023016-17 for CO #002 from Resident Quality Inspection #2017_607523_0007 related to infection prevention and control;
Follow-up Log #023018-17 for CO #003 from Resident Quality Inspection #2017_607523_0007 related to safe and secure home;
Follow-up Log #023013-17 for CO #004 from Resident Quality Inspection #2017_607523_0007 related to bed system assessments.

Inspector #218 (April Tolentino) was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), the acting GM, the Director of Nursing (DON), the assistant DON/Wound Care Lead, Neighbourhood Coordinators (NCs), Resident Assessment Instrument (RAI) Corporate Support, the Kinesiologist/Falls Program Lead, the Director of Recreation, the Personal Expression Resource Team (PERT) Registered Practical Nurse (RPN), the PERT Personal Support Worker (PSW), Ward Clerks, a Recreation Aide, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, reviewed medication administration records, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed specific policies and procedures of the home, reviewed specific program evaluations and reviewed various meeting

minutes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **5 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home's written policy to promote zero

tolerance of abuse and neglect of residents was complied with.

The home submitted multiple Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC) related to allegations of staff to resident abuse or neglect. Over the course of the inspection it was identified through interviews and clinical record reviews that the staff in the home did not comply with the home's written policy on the prevention of abuse and neglect of residents related to the procedures for investigating the allegations, documenting the investigation, follow-up with the accused staff and updating the CIS report.

The home's policy titled "Prevention of Abuse and Neglect" included "Tab 04-06 Investigation Process for Suspected Abuse of a Resident by Team Member, Volunteer or Visitor." This policy included the following procedures:
-"The general manager, member of the leadership team or designate will conduct a full investigation into the incident of abuse. The investigation and Critical Report will be overseen by the general manager in consultation with Human Resources, and will include: a. Documenting the event, including date, time and person; b. Informing the accused team member of the allegation; c. Interviewing the accused team member; d. Individually interviewing witnesses, which could include other team members, residents, volunteers or visitors; e. Interviewing the resident, taking into account the emotional fragility, physical fragility and cognitive functioning of the resident."
- "All witnesses must be interviewed and the facts documented. An Internal Incident Form must be initiated."
-"A detailed description of the incident is to be documented on the resident's record that clearly describes the incident. The documentation is to outline the physical findings, care and treatment provided to all involved."
-"Upon completion of the investigation the general manager or designate leadership team member will meet the accused offender and inform him/her of the results of the investigation and will update the Critical Incident Report."

A) The home submitted a CIS report to the MOHLTC on an identified date reporting alleged neglect of resident by a staff member.

During an interview, the Assistant Director of Nursing (ADON) said there was no documentation of the investigation and that it was the home's expectation that an investigation would be initiated immediately and documented.

During an interview, the Director of Nursing (DON), stated that they could not find the

home's investigation for this incident and that it was the home's expectation that their policy on "Investigation Process for Suspected Abuse of a Resident by Team Member, Volunteer or Visitor" be complied with related to the completion and documentation of an investigation.

B) The home submitted two CIS reports to the MOHLTC on a specified dated reporting alleged neglect of residents by a staff member. One of the CIS reports did not identify the staff member involved. One of the CIS reports stated that the staff member was off pending investigation and that the report would be amended once the investigation was completed.

During an interview, the DON and ADON stated that they could not provide documented evidence that an investigation was completed and that the homes' expectation was that an investigation would have been initiated immediately and documented as per their prevention of abuse and neglect policy.

C) The home submitted a CIS report to the MOHLTC on a specified date which was identified as staff to resident neglect. Within the analysis and follow-up section of this CIS report it stated “team member off pending investigation” and the report did not include further information from subsequent amendments.

During an interview the DON and ADON said that they could not determine if any disciplinary measures were undertaken at the time of the incident and that the documentation was incomplete related to the investigation.

During an interview a Neighbourhood Coordinator (NC) said that they had been involved in the investigation and submission of this CIS report. The NC said there was an investigation that was started in the home but at the time of the inspection there was limited documentation related to this investigation and they could find no documentation.

D) The home submitted a CIS report to the MOHLTC on a specified date which was identified as staff to resident neglect. This report did not include details of the outcome of the home’s investigation .

During an interview an identified staff member said they had reported concerns to a member of the leadership team in the home about the lack of care provided to identified residents on a specific shift.

During an interview an identified staff member said they had been interviewed by members of the leadership team in the home about allegations related to the care they had provided to residents.

During an interview the DON said that they were not working in the home at the time of this incident and there was limited documentation that could be found in the home related to this CIS report.

During an interview the ADON said that they had submitted the CIS report to the MOHLTC based on the investigation completed by other members of the leadership team. The ADON said they were not personally involved in the investigation or follow-up apart from submitting the incident to the MOHLTC. The ADON said that interviews were completed with staff but they were unsure when or by whom as there was no documentation. The ADON said they could find no documentation related to the outcome of the investigation or the overall results.

E) The home submitted a CIS report to the MOHLTC on a specified date which was identified as staff to resident abuse. This report stated that an investigation had occurred in the home but did not include details of the results of the investigation.

During an interview the DON and ADON said that they did not have records for this incident apart from the notes that were documented in the CIS report.

F) The home submitted a CIS report to the MOHLTC on a specified date which was identified as staff to resident neglect.

During an interview the DON and ADON said that they did not have records for this incident apart from the notes that were documented in the CIS report. They said that they were unable to find documentation to indicate if the staff members involved had received discipline or additional education, they were unsure if the staff members had previous history of similar incidents and they were unsure whether any of the residents encountered any negative impacts as a result of the incident.

During another interview the DON said they were not working in the home at the time of this incident and there was limited documentation that could be found in the home related to CIS report apart from the CIS report. DON said they looked in the employee files for these staff members and could find no documentation related to this incident.

During an interview and identified resident said they spoke with a member of the leadership team on a specified date related to concerns about the care they had received from identified staff members.

During an interview with an identified staff member they said they had reported concerns to a member of the leadership team in the home related to the care provided to an identified resident.

During interviews with identified staff members they said that they had been interviewed by members of the leadership team in the home related to the care they had provided to an identified resident at a specific time. The staff members reported that they did not receive follow-up from the leadership in the home related to the outcome of the investigation.

During an interview the General Manager (GM) and Acting GM said the expectation in the home was that the written policy on the prevention of abuse and neglect would be complied with related to the documentation of the investigation and the results of the investigation. The GM and Acting GM said they had identified that there were multiple CIS investigations that had been completed in the home by previous leadership which had not been completed and documented as per the home's written policy on the prevention of abuse and neglect. The Acting GM said it was the expectation in the home that investigations would include documentation of details of the incidents, documentation of interviews completed, documentation of notification of family members, follow-up with the accused staff member and documentation of any education or discipline for those staff members. The GM said they were working on making changes to the process for completing investigations and documentation of the investigations in the home as they had identified with a change in leadership within the home that they needed to improve the process and practices.

Based on these interviews and record reviews the licensee has failed to ensure the home's written policy on the prevention of abuse and neglect was complied with in relation to the procedures for conducting and documenting investigations into allegations of staff to resident abuse and neglect.

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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b).

The home had submitted multiple Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC) related to controlled substances that were missing/unaccounted and related to medication administration. Over the course of the inspection it was identified through interviews and clinical record reviews that the

medication incidents related were not reviewed and analyzed or that corrective actions were taken as necessary. It was also identified that there were no written records related to the review, analysis or corrective actions for these incidents.

The home's policy "4.15 Medication Incidents" stated in part: "Procedure: all Medication Incidents or near misses (Home or Pharmacy derived) MUST be reported, and documented on the Medication Incident/Near Miss Report. Alert the Pharmacy immediately if the incident has originated at the Pharmacy. Initiate a Remedy's Medication Incident/Near Miss Report documenting: resident name, date and time of incident, indicate type of incident and circle specific example, description of incident, medication involved, effect on resident, follow-up actions taken, attach a copy of Medication Administration Record/electronic Medication Administration Record report and any other supporting documentation, attach a copy of Medication pouch/copy of Medication Label if applicable."

During an interview the DON said that there was no documentation of the review or analysis of medication incidents

2. The licensee has failed to ensure that: (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review were implemented; and (c) a written record was kept of everything provided for in clause (a) and (b).

The home had submitted multiple CIS reports to the MOHLTC related to controlled substances missing/unaccounted and related to medication administration. Over the course of the inspection it was identified through interviews and clinical record reviews that there was not a quarterly review of all medication incidents or adverse drug reactions.

A review of the home's policy "4.15 Medication Incidents" stated "A medication incident program is in place in the home to ensure there is a consistent method for identification, reporting, reviewing and analyzing of all medication incidents. All medication incidents are reviewed and analyzed quarterly by the Professional Advisory Committee (PAC) and recommendations for system improvements developed. The purpose of the medication incident program is to identify opportunities for improving the medication management system in the home and to prevent future incidents from occurring rather than targeting

individual practices."

A review of the home's Medication Incidents binder showed no documented evidence that a quarterly review was completed, that any changes and improvements were identified or that there was a written record kept.

During an interview the DON stated there was no documentation that medication incidents were reviewed quarterly or that changes and improvements were identified. The DON said that the home needed to implement the program.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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, (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review are implemented; and (c) a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based

on an assessment of the resident and the needs and preferences of that resident.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date related to an incident for an identified resident.

A review of the clinical record for this identified resident showed that this resident had been assessed related to a specific safety risk by an identified staff member. A review of the plan of care for this resident showed that it had not been updated based on the assessed need of the resident related to the safety risk.

During an interview the Director of Nursing (DON) stated that the plan of care for this identified resident did not reflect the needs of this resident related to this specific area of care and safety risk.

The licensee has failed to ensure that the care set out in the plan was based on the assessment and needs of that resident.

2. The licensee has failed to ensure that the care set out in the plan was provided to the resident as specified in the plan.

The home submitted a CIS report to the MOHLTC on a specified date related to an incident for an identified resident.

During an interview with multiple staff in the home it was reported that this identified resident had a specific device in place to help reduce a specific safety risk for this resident.

A review of the clinical record for this identified resident showed they had been assessed as needing a specific device to minimize a specific safety risk and that this had been added to the resident's plan of care.

During an interview a Neighbourhood Coordinator reported that based on an investigation done by the home it was determined that an identified staff member had not applied a specific device on a specific date for the identified resident.

Based on these interviews and record review the home failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of every investigation taken under clause s. 23 (1) (a) and every action taken under clause s. 23 (1)(b) were reported to the Director.

The home submitted multiple Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC) related to allegations of staff to resident abuse or neglect. Over the course of the inspection it was identified through interviews and clinical record reviews that identified CIS reports were not updated to include every action taken related to the allegation and the results of the home's investigation.

The home's policy titled "Tab 04-06B - Investigation Process for Suspected Abuse of a resident by Team Member, Volunteer or Visitor" stated in part: "Upon completion of the investigation the general manager or designate leadership team will meet the accused offender and inform him/her of the results of the investigation and will update the Critical Incident Report."

A) The home submitted a CIS report to the MOHLTC on a specified date which was

identified as staff to resident neglect. This CIS report did not include the short term or long term actions that were implemented in the home.

During an interview the DON and ADON said that they did not have access to determine if any disciplinary measures were undertaken with staff at the time of the incident.

During an interview a Neighbourhood Coordinator (NC) said that they had been involved in the investigation and submission of the CIS report. The NC acknowledged that the results of the investigation and actions taken were not reported to the MOHLTC.

B) The home submitted two CIS reports to the MOHLTC on a specified date reporting alleged neglect of residents by a staff member. During a review of the CIS reports it was found that the home had no documented evidence that an investigation was completed and did not report the results and action taken to the MOHLTC.

During an interview a NC said that after the investigation they needed to amend the CIS for the outcome which they recently learned and they were not sure about what else to do after the investigation was completed.

During an interview with the DON and ADON they said that the results of the investigation were not reported to the Director and that it was the expectation that the reports would be updated to include the actions and results.

C) The home submitted a CIS report to the MOHLTC on a specified date which was identified as staff to resident neglect. This report did not include the outcome of the investigation.

During an interview the ADON said that they had submitted to the MOHLTC based on the investigation completed by other members of the leadership team. The ADON said they were not personally involved in the investigation or follow-up apart from submitting the incident to the MOHLTC. The ADON and they said that there was no documentation to indicate what happened with the staff involved as a result of the CIS, contact with the family or the outcome of the investigation.

During an interview the General Manager (GM) and the Acting GM said the expectation in the home was that CIS reports to the MOHLTC would be updated with the results and actions taken related to investigations into allegations of staff to resident abuse or neglect. The GM said they were working on making changes to the process for

completing investigations and updating CIS reports in the home as they had identified with a change in leadership within the home that they needed to improve the process and practices.

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 they report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

The home submitted multiple Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC) related to allegations of staff to resident abuse or neglect. Over the course of the inspection it was identified through interviews and clinical record reviews that the allegations and the information upon which they were based were not reported immediately to the Director.

The home's policy titled "Tab 04-06 Prevention of Abuse and Neglect" stated in part: "all team members are required to report any suspicions, incidents, or allegations of neglect and/or abuse immediately to any supervisor or any member of the leadership team for further investigation, and follow Section 24-Mandatory Reports".

A) The home submitted a CIS report to the MOHLTC on a specified day reporting alleged neglect of an identified resident by a staff member. The report showed that the incident had not been reported to the MOHLTC immediately.

During an interview the Assistant Director of Nursing (ADON) stated that and identified staff member reported concerns regarding the care of a resident to a Neighbourhood Coordinator (NC) at the time of the incident. The ADON stated that the NC did not report the alleged neglect immediately to them. ADON stated that they did the CIS report the day they were informed and that the home's expectation was that suspicions of abuse were to be reported to the MOHLTC immediately.

During an interview, the Director of Nursing (DON) stated that Neighbourhood Coordinators were part of the leadership team who were completing CIS reports when needed at the time of the incident. DON added that the NC should have reported the incident immediately to the MOHLTC.

B) The home submitted a CIS report to the MOHLTC on a specified date with allegation of neglect by a staff member to an identified resident. The CIS report showed that this was not reported immediately to the MOHLTC.

A review of discipline letters to the two staff members involved showed that the written disciplinary letter was dated prior to the CIS report being submitted to the MOHLTC. In an interview the ADON stated that the management of the home knew about the incident three days prior to notifying the MOHLTC through the CIS report. The ADON stated that the home investigated the occurrence and found that neglect had occurred. The ADON stated that the home had not immediately reported that neglect had occurred and it was the expectation that this would have been reported immediately.

C) The home submitted a CIS report to the MOHLTC on a specified date reporting alleged neglect of resident by a staff member. This report showed that a NC had knowledge of the alleged neglect on the date of the incident and did not report to the Director immediately.

During an interview the DON and the ADON stated that the incident was neglect and that the home's expectation was that incidents of abuse or neglect would be reported immediately to the Director.

D) The home submitted a CIS report to the MOHLTC on a specified date reporting alleged neglect of an identified resident by a staff member. This report showed a Neighbourhood Coordinator had knowledge of the alleged neglect on a specified date and did not report to the Director immediately.

During an interview, the DON and the ADON stated that the incident was neglect and that the home's expectation was that incidents of abuse or neglect would be reported immediately to the Director.

E) The home submitted a CIS report to the MOHLTC on a specified date reporting alleged neglect of a resident by a staff member. The report showed that a member of the leadership team in the home knowledge of the alleged neglect and did not report to the Director immediately.

During an interview, the DON and ADON stated that the incident was neglect and that the home's expectation was that incidents of abuse or neglect would be reported immediately to the Director.

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 any person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The home's policy titled "3.12 Medication Management Audit/eAudit" with revised dated of March 1, 2016, stated "to assist each Home with its Risk Management and Quality Improvement activities, Remedy's Rx staff shall conduct quarterly scheduled audits to ensure compliance with the applicable regulations, accreditation standards and professional standards of practice".

A review of the home's "Medication Audits" found an evaluation/audit of the medication management system with a specific date. There were no other documented evaluations/audits after that date.

During an interview, the Director of Nursing (DON) stated that they could only provide the evaluation/audit of the medication management system from a specific date, and that there were no other audits completed since that time. The DON said that it was the home's expectation to have a medication management system quarterly evaluation by an interdisciplinary team.

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 an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone.

The following evidence is further grounds to support Compliance Order (CO) #001 related to LTCHA, 2007 S.O. 2007, c.8, s. 19(1) issued in Inspection #2017_607523_0007 with a compliance due date of October 31, 2017.

The home had submitted multiple Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC) related to allegations of resident to resident abuse by an identified resident towards other residents. Over the course of the inspection it was found through interviews and clinical record reviews that the home failed to protect residents from the responsive behaviours of this identified resident. It was also found that residents in the home continued to be at risk related to this identified resident's responsive behaviours.

A) The home submitted a CIS report to the MOHLTC on a specified date which was identified as a specified type of potential resident to resident abuse. This report stated that the incident had been observed by a team member and that an identified resident reported specific actions of the other identified resident.

During an interview with an identified resident they reported details related to the allegations of resident to resident abuse.

During an interview with an identified staff member they said that an identified resident had reported to them concerns about the actions of another identified resident. This staff member said they reported this incident to a member of the leadership team in the home right away.

During an interview with a Neighbourhood Coordinator (NC) they said they were aware of the incidents that occurred between these two identified residents as they had been

informed by a staff member. They said they started an intervention for a specific period of time and then had no further involvement in the incident. When asked if they thought the interventions that were in place at the time of the incident were effective the NC said that they were not effective enough.

B) The home submitted a CIS report to the MOHLTC on another specified date was identified as potential resident to resident abuse. This report stated that an identified resident was found in another identified resident's room with specified responsive behaviours.

A review of the clinical record for the identified resident with responsive behaviours showed this resident had been assessed as having a specific type of responsive behaviours and had interventions in place at the time of the incidents. This clinical record showed that the physician had assessed the identified resident prior to this incident and identified that the resident's behaviour was unacceptable and that previous changes had not helped with the behaviours.

During interviews with identified staff members it was reported that this resident had ongoing specific responsive behaviours and the interventions had not been effective in preventing this resident from touching other residents in the home.

During an interview the Director of Nursing (DON) said they were not working in the home at the time of the incident and therefore had not been involved in the investigation of follow-up of the incidents. The DON said that the staff and leadership in the home were aware of the behaviours and multiple resources had been actively involved in ongoing efforts to develop strategies. The DON said that they thought the interventions in place after the last reported CIS had been effective in preventing other incident of reported abuse. The DON said that at the time of the inspection they were working to make further changes to the interventions that were in place to prevent incidents from happening again. The DON said it was the expectation in the home that residents and staff in the home were safe.

Based on these interviews and record review the home failed to ensure that effective strategies were in place to minimize the risk of abuse between this identified resident and other residents on specified dates. Staff and management in the home were aware of the potential risks due to a history of prior Critical Incidents of resident to resident abuse between this resident and other residents. The staff and management in the home identified that at the time of the inspection there remained a risk to other resident's safety

related to this resident's responsive behaviours and further assessments and revisions to the plan of care were needed to ensure resident and staff safety.

2. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The following evidence is further grounds to support Compliance Order (CO) #001 related to LTCHA, 2007 S.O. 2007, c.8, s. 19(1) issued in Inspection #2017_607523_0007 with a compliance due date of October 31, 2017.

The home had submitted multiple CIS reports to the MOHLTC related to allegations of staff to resident abuse or neglect. Over the course of the inspection it was identified through interviews and clinical record reviews that the home failed to protect residents from neglect or abuse from identified staff members. It was also identified that there was a pattern of inaction within the home related to the investigation of the allegations of neglect and abuse by staff.

A) The home submitted a CIS report to the MOHLTC on a specified date reporting alleged neglect of an identified resident by a staff member. The CIS included details related to the care concerns that were reported to the leadership in the home by another staff member.

During interviews with identified staff members they said that they thought the care provided to this identified resident could be considered alleged abuse or neglect.

The leadership in the home at the time of the inspection could not provide documented evidence that an investigation of the incident was completed.

During an interview the Assistant Director of Nursing (ADON) said that this incident was considered neglect and that the homes' expectation was that residents would be protected from abuse and neglect.

During an interview the DON stated that the home's expectation was that there were zero tolerance for abuse and neglect.

B) The home submitted a CIS report to the MOHLTC on a specified date reporting alleged neglect to an identified resident by an identified staff member. The CIS report included details related to these allegations.

During an interview an identified staff member stated they remembered the incident and believed it was neglect and reported this to management in the home.

The leadership in the home at the time of the inspection could not provide documented evidence that an investigation of the incident was completed.

During an interview, the DON and ADON said that the incident was neglect and that the home's expectation was that there were zero tolerance for abuse and neglect and those residents should have been protected from abuse and neglect.

C) The home submitted a CIS report to the MOHLTC on a specified date reporting alleged neglect of another identified resident by an identified staff member. This report included details related to these allegations.

During an interview, an identified staff member stated they remembered the incident and believed it was neglect.

The leadership in the home at the time of the inspection could not provide documented evidence that an investigation of the incident was completed.

During an interview the DON and the ADON said that the incident was neglect and that the home's expectation was that there were zero tolerance for abuse and neglect and those residents should have been protected from abuse and neglect.

D) The home submitted a CIS report to the MOHLTC on a specified date reporting alleged neglect of an identified resident by an identified staff member. The CIS report showed that the staff member had neglected the resident in a specific way and spoken to the resident in a specified way.

A review of the identified resident's care plan showed that it stated in part that they required assistance with this specific care.

During an interview with the identified resident they reported details related to the alleged abuse and neglect.

The leadership in the home at the time of the inspection could not provide documented evidence that an investigation of the incident was completed.

During an interview the ADON stated that this incident was abuse and that the home's expectation is that residents should be protected from abuse and neglect.

During an interview the DON stated that if the investigations were conducted on the incidents related to allegation of staff to resident abuse and neglect by the identified resident and the results of the investigations recorded and reported, then the leadership in the home would have seen the trend with this identified staff member and their actions towards the residents.

Based on these interviews and record review the home has failed to ensure that residents were protected from emotional abuse and neglect from identified staff members.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that when everything required under subsection (1) could not be provided in a report within 10 days, the licensee made a preliminary report to the Director within 10 days and provided a final report to the Director within a period of time specified by the Director.

The home submitted a CIS report to the MOHLTC on a specified date which was identified as staff to resident neglect. This report showed that it was amended 61 days after a request was made by the MOHLTC related to the outcome of the home's internal investigation and actions taken to prevent recurrence.

During an interview the DON said that they were not working in the home at the time of this incident and there was limited documentation that could be found in the home related to this CIS report apart from the CIS report. The DON said they were unable to determine when the investigation was completed.

During an interview the GM and Acting GM said the expectation in the home that the CIS report would be updated with the results of an investigation upon completion of the investigation. They acknowledged that the CIS report was not updated with the outcome of the investigation when it had been completed by the leadership in the home. The GM said they were working on making changes to the process for completing investigations and documentation of the investigations in the home as they had identified with a change in leadership within the home that they needed to improve the process and practices.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when they were required to inform the Director of an incident under subsection (1), (3) or (3.1) they shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the outcome or current status of the individuals who were involved in the incident.

The home submitted a CIS report to the MOHLTC on a specified date. Upon review of the report, an identified resident had sustained a fall in which they were transferred to hospital. The report showed an amendment was requested by the MOHLTC on a specified date requesting the outcome and the status of resident upon returning from hospital.

A review of the resident's clinical record showed that the resident had a significant change in status and sustained a specified injury.

In an interview with the DON they stated that the amendment to the CIS was not completed as requested by the Director.

The licensee has failed to ensure that when they were required to inform the Director of an incident that they made a report in writing to the Director which set out the outcome or current status of the individuals who were involved, within 10 days of becoming aware of the incident.

Issued on this 13th day of February, 2018

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMIE GIBBS-WARD (630), ADAM CANN (634), HELENE DESABRAIS (615)
Inspection No. / No de l'inspection :	2018_262630_0004
Log No. / No de registre :	012992-16, 013262-16, 033839-16, 034425-16, 005230-17, 007416-17, 008994-17, 009025-17, 010241-17, 014455-17, 014795-17, 016725-17, 016860-17, 016971-17, 019291-17, 020021-17, 020894-17, 021492-17, 021493-17, 021494-17, 021504-17, 021787-17, 023008-17, 023565-17, 027916-17, 029582-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 9, 2018
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
	Cindy Awde

Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with.

Specifically the licensee shall ensure that all charge nurses and leadership team members in the home, who are outlined in the home's written policy as being responsible for procedures within the "Investigation Process for Suspected Abuse of a Resident By a Team Member, Volunteer or Visitor", comply with the written policy related to the investigation process.

The licensee shall ensure that all charge nurses and leadership team members are re-educated on the home's "Prevention of Abuse and Neglect" policy including: the investigation process; documentation of the home's investigation and actions taken within an investigation; follow-up with accused staff members after an investigation is completed; and the home's procedures for mandatory reporting to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home submitted multiple Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC) related to allegations of staff to resident abuse or neglect. Over the course of the inspection it was identified through interviews and clinical record reviews that the staff in the home did not comply with the home's written policy on the prevention of abuse and neglect of

residents related to the procedures for investigating the allegations, documenting the investigation, follow-up with the accused staff and updating the CIS report.

The home's policy titled "Prevention of Abuse and Neglect" included "Tab 04-06 Investigation Process for Suspected Abuse of a Resident by Team Member, Volunteer or Visitor." This policy included the following procedures:
-"The general manager, member of the leadership team or designate will conduct a full investigation into the incident of abuse. The investigation and Critical Report will be overseen by the general manager in consultation with Human Resources, and will include: a. Documenting the event, including date, time and person; b. Informing the accused team member of the allegation; c. Interviewing the accused team member; d. Individually interviewing witnesses, which could include other team members, residents, volunteers or visitors; e. Interviewing the resident, taking into account the emotional fragility, physical fragility and cognitive functioning of the resident."
- "All witnesses must be interviewed and the facts documented. An Internal Incident Form must be initiated."
-"A detailed description of the incident is to be documented on the resident's record that clearly describes the incident. The documentation is to outline the physical findings, care and treatment provided to all involved."
-"Upon completion of the investigation the general manager or designate leadership team member will meet the accused offender and inform him/her of the results of the investigation and will update the Critical Incident Report."

A) The home submitted a CIS report to the MOHLTC on an identified date reporting alleged neglect of resident by a staff member.

During an interview, the Assistant Director of Nursing (ADON) said there was no documentation of the investigation and that it was the home's expectation that an investigation would be initiated immediately and documented.

During an interview, the Director of Nursing (DON), stated that they could not find the home's investigation for this incident and that it was the home's expectation that their policy on "Investigation Process for Suspected Abuse of a Resident by Team Member, Volunteer or Visitor" be complied with related to the completion and documentation of an investigation.

B) The home submitted two CIS reports to the MOHLTC on a specified dated

reporting alleged neglect of residents by a staff member. One of the CIS reports did not identify the staff member involved. One of the CIS reports stated that the staff member was off pending investigation and that the report would be amended once the investigation was completed.

During an interview, the DON and ADON stated that they could not provide documented evidence that an investigation was completed and that the homes' expectation was that an investigation would have been initiated immediately and documented as per their prevention of abuse and neglect policy.

C) The home submitted a CIS report to the MOHLTC on a specified date which was identified as staff to resident neglect. Within the analysis and follow-up section of this CIS report it stated "team member off pending investigation" and the report did not include further information from subsequent amendments.

During an interview the DON and ADON said that they could not determine if any disciplinary measures were undertaken at the time of the incident and that the documentation was incomplete related to the investigation.

During an interview a Neighbourhood Coordinator (NC) said that they had been involved in the investigation and submission of this CIS report. The NC said there was an investigation that was started in the home but at the time of the inspection there was limited documentation related to this investigation and they could find no documentation.

D) The home submitted a CIS report to the MOHLTC on a specified date which was identified as staff to resident neglect. This report did not include details of the outcome of the home's investigation .

During an interview an identified staff member said they had reported concerns to a member of the leadership team in the home about the lack of care provided to identified residents on a specific shift.

During an interview an identified staff member said they had been interviewed by members of the leadership team in the home about allegations related to the care they had provided to residents.

During an interview the DON said that they were not working in the home at the time of this incident and there was limited documentation that could be found in

the home related to this CIS report.

During an interview the ADON said that they had submitted the CIS report to the MOHLTC based on the investigation completed by other members of the leadership team. The ADON said they were not personally involved in the investigation or follow-up apart from submitting the incident to the MOHLTC. The ADON said that interviews were completed with staff but they were unsure when or by whom as there was no documentation. The ADON said they could find no documentation related to the outcome of the investigation or the overall results.

E) The home submitted a CIS report to the MOHLTC on a specified date which was identified as staff to resident abuse. This report stated that an investigation had occurred in the home but did not include details of the results of the investigation.

During an interview the DON and ADON said that they did not have records for this incident apart from the notes that were documented in the CIS report.

F) The home submitted a CIS report to the MOHLTC on a specified date which was identified as staff to resident neglect.

During an interview the DON and ADON said that they did not have records for this incident apart from the notes that were documented in the CIS report. They said that they were unable to find documentation to indicate if the staff members involved had received discipline or additional education, they were unsure if the staff members had previous history of similar incidents and they were unsure whether any of the residents encountered any negative impacts as a result of the incident.

During another interview the DON said they were not working in the home at the time of this incident and there was limited documentation that could be found in the home related to CIS report apart from the CIS report. DON said they looked in the employee files for these staff members and could find no documentation related to this incident.

During an interview and identified resident said they spoke with a member of the leadership team on a specified date related to concerns about the care they had received from identified staff members.

During an interview with an identified staff member they said they had reported concerns to a member of the leadership team in the home related to the care provided to an identified resident.

During interviews with identified staff members they said that they had been interviewed by members of the leadership team in the home related to the care they had provided to an identified resident at a specific time. The staff members reported that they did not receive follow-up from the leadership in the home related to the outcome of the investigation.

During an interview the General Manager (GM) and Acting GM said the expectation in the home was that the written policy on the prevention of abuse and neglect would be complied with related to the documentation of the investigation and the results of the investigation. The GM and Acting GM said they had identified that there were multiple CIS investigations that had been completed in the home by previous leadership which had not been completed and documented as per the home's written policy on the prevention of abuse and neglect. The Acting GM said it was the expectation in the home that investigations would include documentation of details of the incidents, documentation of interviews completed, documentation of notification of family members, follow-up with the accused staff member and documentation of any education or discipline for those staff members. The GM said they were working on making changes to the process for completing investigations and documentation of the investigations in the home as they had identified with a change in leadership within the home that they needed to improve the process and practices.

Based on these interviews and record reviews the licensee has failed to ensure the home's written policy on the prevention of abuse and neglect was complied with in relation to the procedures for conducting and documenting investigations into allegations of staff to resident abuse and neglect.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on October 6, 2015, Critical Incident System (CIS) Inspection #2015_262523_0027 as a Voluntary Plan of Correction (VPC) and on October 6, 2015, in a Complaint Inspection #2015_262523_0026 as a VPC. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2018

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. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions 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). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee shall ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed and that corrective actions are taken as necessary.

The licensee shall ensure that a written record is kept of each medication incident and each adverse drug reaction and this documentation is to include the review, analysis and corrective actions taken.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b).

The home had submitted multiple Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC) related to controlled substances that were missing/unaccounted and related to medication administration. Over the course of the inspection it was identified through interviews and clinical record reviews that the medication incidents related were not reviewed and analyzed or that corrective actions were taken as necessary. It was also identified that there were no written records related to the review, analysis or corrective actions for these incidents.

The home's policy "4.15 Medication Incidents" stated in part: "Procedure: all Medication Incidents or near misses (Home or Pharmacy derived) MUST be reported, and documented on the Medication Incident/Near Miss Report. Alert the Pharmacy immediately if the incident has originated at the Pharmacy. Initiate a Remedy's Medication Incident/Near Miss Report documenting: resident name, date and time of incident, indicate type of incident and circle specific example, description of incident, medication involved, effect on resident, follow-up actions taken, attach a copy of Medication Administration Record/electronic Medication Administration Record report and any other supporting documentation, attach a copy of Medication pouch/copy of Medication Label if applicable."

During an interview the DON said that there was no documentation of the review or analysis of medication incidents

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on June 20, 2017, in Critical Incident System (CIS) Inspection #2017_263524_0018 as a Voluntary Plan of Correction (VPC) and on April 13, 2017, in Resident Quality Inspection (RQI) #2017_607523_0007 as a VPC. (615)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Amie Gibbs-Ward

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