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
Aug 22, 2018	2018_674610_0012	016118-18	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

NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 9, 2018

This inspection was a Critical Incident System (CIS) report #2979-000043-18, Log #016115-18, and Complaint Log# 016118-18.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Associate Director of Care, Personal Support Worker, and Neighbourhood Coordinator.

Inspector observed resident care areas, conducted interviews, reviewed relevant documentation and health care records.

The following Inspection Protocols were used during this inspection:
Pain
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 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. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee failed to ensure that every resident received end-of-life care when required in a manner that met their needs.

This inspection was related to a Critical Incident System (CIS) report and Complaint submitted to the Director from the home.

An identified resident's documentation showed that the resident had a significant change in status and intervention that had been in place were ineffective in maintaining the resident's comfort.

The homes policy stated in part that when there was a change in condition with pain onset, or diagnosis of a painful disease where pain was expressed or symptoms exhibited by the resident reports of pain greater than 4/10 on a severity scale of 72 hours, a pain assessment would be conducted when a scheduled pain medication did not relieve pain, regardless of the support strategies and when pain medication had been changed.

Review of the resident's documentation showed the home had not completed an assessment when there was a change in the medication to manage the resident's discomfort.

Further documentation showed that the medication administered was ineffective for the resident and that the staff did not call the physician for other options when the current medication was not effective in managing the resident’s symptoms.

The pharmacy policy for after hours emergency pharmacy services stated in part that emergency pharmacy services would be available "to ensure your home was receiving after hours Pharmacy support” and "as a general guideline, requests for dispensing of a medication after hours is subject to the discretion of the on-call Pharmacist and limited to the following situations: Pain or palliative care medications”.

The Administrator stated that the home should have completed an assessment using a clinically appropriate assessment tool when the resident was experiencing discomfort. The staff should have contacted the physician when the intervention were ineffective for the resident and had not. The pharmacy was an out of town pharmacy service provider, and that the on call emergency pharmacy was closer and should have provided the medication to assist with the resident's comfort and had not.

The licensee failed to ensure that every resident received end-of-life care when required in a manner that meet the resident's needs. [s. 42.]

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 shall ensure that every resident receives end-of-life care when required in a manner that meet their needs, to be implemented voluntarily.

WN #2: 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. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).
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. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident 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. 104 (1).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident: 2. A description of the individuals involved in the incident, including, i. names of all residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or were responding to the incident.

A Critical Incident System (CIS) report had been submitted to the Ministry of Health and Long Term Care (MOHLTC) by the home.

Further review of the CIS report showed that a complaint was submitted to the home's staff from an identified resident's family member. The Critical Incident System (CIS) report did not identify the resident, the staff members involved, or the name of the staff member who responded to the incident, and that the date and time of the occurrence was reported incorrectly.

The Assistant Director of Care stated that they had received education related to making a report to the Director, but failed to ensure that the CI date and time of the incident was correct, and failed to include the description of the resident’s name, the staff names, and the staff that reported the incident to the Director. [s. 104. (1)]

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 making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident: 2. A description of the individuals involved in the incident, including, i. names of all residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident, to be implemented voluntarily.

Issued on this 22nd day of August, 2018

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

Original report signed by the inspector.