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
Sep 14, 2018	2018_606563_0013	014846-18	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

MELANIE NORTHEY (563), CASSANDRA ALEKSIC (689), DONNA TIERNEY (569), HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 3, 7, 8, 9, 10, 13, 14, 15, 16, and 17, 2018

The following Critical Incident (CI) and Complaint intakes were completed as part of the Resident Quality Inspection:

Related to Falls Prevention:
Log #006225-18 / CI #2979-000017-18

Log #011417-18 reviewed for CI #2979-000031-18
Log #015931-18 / CI #2979-000044-18

Related to Medication Management:
Log #004911-18 / CI #2979-000014-18
Log #004369-18 / CI #2979-000015-18
Log #004445-18 / Complaint IL-55797-LO
Log #008731-18 / CI #2979-000022-18
Log #015783-18 / CI #2979-000042-18

Related to the Prevention of Abuse and Neglect:
Log #013892-17 / CI #2979-000058-17
Log #016195-17 / CI #2979-000069-17
Log #002791-18 / CI #2979-000005-18
Log #006967-18 / Complaint IL-56352-LO
Log #012473-18 / CI #2979-000036-18
Log #013108-18 / CI #2979-000037-18
Log #014050-18 / CI #2979-000039-18

Related to Safe and Secure Home:
Log #020431-17 / CI #2979-000082-17
Log #022346-17 / CI #2979-000096-17
Log #014988-18 / CI #2979-000041-18

The following Follow-Up Compliance Order (CO) intakes were completed:
Log #003500-18 / follow-up CO #001 from CI Inspection #2018_262630_0004
Log #003504-18 / follow-up CO #002 from CI Inspection #2018_262630_0004

The following Critical Incident (CI) intakes were completed as an onsite inquiry:
Log #001183-18 / CI #2979-000001-18 related to staff to resident suspected verbal abuse
Log #003589-18 / CI #2979-000010-18 related to staff to resident suspected verbal abuse
Log #027326-17 / CI #2979-000103-17 related to staff to resident suspected verbal abuse
Log #016216-18 / CI #2979-000045-18 related to resident to resident abuse
Log #009542-18 / CI #2979-000028-18 reviewed related to a missing resident
Log #002928-18 / CI #2979-000008-18 reviewed related to a fall

Log #002953-18 / CI #2979-000006-18 reviewed related to a fall
Log #003730-18 / CI #2979-000012-18 reviewed related to a fall

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Care, the Assistant Director of Care, the Personal Expression Resource Team Lead, the Resident Assessment Instrument Coordinator, the Director of Environmental Services, the Social Worker, the Exercise Therapist, the Assistant Director of Food Services, Neighbourhood Coordinators, Registered Nurses, Registered Practical Nurses, Personal Support Workers, the Residents' Council president, the Family Council Representative, residents and family members.

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

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

11 WN(s)
5 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 135. (2)	CO #002	2018_262630_0004	615

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

Section 2(1) of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

A Critical Incident System (CIS) report documented improper treatment of a resident. The CIS stated nursing measures were provided, a specific medication was ordered by the Nurse Practitioner and sample was to be sent for analysis. The medication order was not processed by the day the Registered Practical Nurse (RPN) or evening the RPN and a sample was not collected. The first dose of medication was administered in the morning of the next day. The resident’s physician was contacted as the resident was exhibiting acute medical symptoms and was transferred to acute care.

The progress notes in Point Click Care (PCC) for the resident documented ongoing symptoms of an acute medical condition, the late administration of a specific medication, a sample was ordered by the Nurse Practitioner but was not taken.

The home's investigation notes documented an interview by the on-call manager, the Director of Environmental Services (DES) and the RPN and stated that the medication order was not processed and there was no first and second check by the registered staff and “that's neglect/incompetence from us, it's a big deal with the Ministry”. The RPN verified the medication was not administered to the resident on time.

The electronic Medication Administration Record (eMAR) in PCC for the resident documented that the first documented dose was given late.

The RPN stated if a resident received an order for a specific medication, the order was to be processed using a digipen and sent to pharmacy. The RPN added that in the meantime, the registered staff would go to contingency, get the medication, start the dose and document this in the eMAR. The RPN was the staff member working the day shift and shared that the resident was administered the specific medication late.

The Assistant Director of Care (ADOC) stated they became aware of the critical incident when the on-call manager, the DES, brought it forward during the leadership huddle the next day and the DES stated they had already initiated the CIS and submission to the MOHLTC related to the improper/incompetent treatment of the resident. The ADOC verified that the day the RPN did not pass on the information regarding the resident’s

medication order to the oncoming evening RPN and did not process the order and it was a high risk medication order. The ADOC also stated that a higher alert medication order can be put in PCC by the nurse and the medication can be retrieved from the contingency box and this did not happen related to the resident's specific medication order. The ADOC stated the contingency box was the emergency stock medications kept in the home, but that the registered staff also have access to the on-call pharmacy for those medications not available but need to be started, and the medications would be dispatched right away. The ADOC verified that the order for the medication was received on and the first dose was administered the following day. The ADOC stated neglect was failure to provide the expected level of care or services to the resident and acknowledged that the incident involving the resident met the definition of neglect as stated in the Long Term Care Homes Act. The ADOC also acknowledged that there was a breakdown in communication that led to the omission of a high alert medication to be administered to the resident; and the emergency stock medications were not utilized to ensure the resident received the medication required for health and well being.

The Remedy's Rx Emergency Stock Box Policy Number 3.9 last revised March 1, 2016, stated the emergency stock box was available to provide an emergency supply of medications allows registered staff to begin medication therapy upon receipt of a prescriber's order to prevent any delay in treatment.

The licensee failed to ensure that the resident was free from neglect by the licensee or staff in the home. The resident's status had deteriorated and the resident was assessed by the Nurse Practitioner (NP). At that time, the NP ordered a sample for analysis and a specific medication, but the medication was not administered until the next day. The day RPN and the evening RPN did not ensure the order was processed and that the medication was received from pharmacy. The registered staff did not obtain the medication from contingency to administer it. Although a progress note documented that a sample could have been obtained as ordered, it was not. The resident was transferred to acute care.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was isolated. The home had a level 4 compliance history since despite Ministry of Health (MOH) action non-compliance (NC) continues with original area of NC with this section of the LTCHA that included:
• October 6, 2015: Voluntary Plan of Correction (VPC) during Complaint inspection #2015_262523_0026.
• March 14, 2016: Compliance Order (CO) #004 was issued May 12, 2016 with

compliance due date May 31, 2016 during Resident Quality Inspection (RQI) #2016_262523_0016 and was closed with a link on July 11, 2016.
• June 28, 2016: CO #003 and linked to CO #004 was issued July 27, 2016 with compliance due date August 31, 2016 during Follow Up inspection #2016_262523_0026 and was complied September 30, 2016.
• January 31, 2017: VPC during Complaint inspection 32017_538144_0009.
• April 13, 2017: CO #001 issued September 12, 2017 with compliance due date October 31, 2017 during RQI #2017_607523_0007 and was complied February 2, 2018.
• June 19, 2017: VPC during Complaint inspection #2017_263524_0017.
• June 20, 2017: VPC during Critical Incident (CI) inspection #2017_263524_0018.
• January 18, 2018: Written Notification (WN) during CI inspection #2018_262630_0004 as further evidence to support CO #001 from RQI #2017_607523_0007. [s. 19. (1)]

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 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 :

1. The licensee failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

The Schlegel Villages Code of Conduct Prevention of Abuse and Neglect Policy Tab 04-06 stated, "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 to follow Section 24 – Mandatory Reports. [LTC Act s. 24]." "All team members, students and volunteers who witness or suspect the abuse of a resident, or receive complaints of abuse, are required to report the matter

immediately to any supervisor including the charge nurse, or any member of the leadership team.” The policy documented “lack of privacy” and “ignoring resident, or a request for assistance” as a form of emotional abuse.

A resident was interviewed during stage “1” of the Resident Quality Inspection. The Inspector asked the question, "Do you feel the staff treats you with respect and dignity? For example, do staff take the time to listen to you and are staff helpful when you request assistance?" and the resident answered "no". The resident stated there was a specific time during care when they felt staff were not providing the help they needed. The resident then showed the Inspector a typed note and stated the nurse on the night shift typed it for them from their handwritten notes. The resident stated they were going to report the recent incident to the Director of Care (DOC) today because this should have never happened.

The letter typed by the RPN for resident documented the incident occurred. The letter documented that the resident felt belittled, discouraged, humiliated, and degraded.

The home submitted the written complaint by the resident to the Ministry of Health and Long-Term Care (MOHLTC) related to allegations of staff to resident abuse or neglect and the incident was immediately investigated where the allegations were unfounded. However, over the course of the inspection it was identified through interviews and 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 immediate reporting of alleged staff to resident abuse or neglect.

The licensee failed to ensure that the Schlegel Villages Code of Conduct Prevention of Abuse and Neglect Policy Tab 04-06 was complied with. The policy promoted zero tolerance of abuse and neglect of residents and stated “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.” The RPN wrote a progress note documenting the resident’s conversation with a table mate related to the incident and did not report this to the Charge Nurse or a member of the leadership team. A second RPN was made aware of the allegation of staff to resident abuse when they typed the resident’s letter to the DOC and did not report the allegation immediately to the leadership team. The RN who was the charge nurse stated having no knowledge of the allegations of abuse until the end of their shift. The RN was uncertain if they reported this to the DOC. The resident was the one who reported the allegation to the DOC.

The Village of Glendale Crossing were required to comply with Compliance Order (CO) #001 related to "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." CO #001 was to be complied. Specifically the licensee was to 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.

The General Manager (GM) verified that charge nurses and leadership team members were educated as documented in the CO #001. The GM stated that the home also educated the RPNs and verified that the RPNs were the team leads for the neighbourhoods. The Inspector and the GM reviewed of the education attendance and the GM stated that those staff whose names were highlighted green on the "Schedule Worksheet" for RNs and RPNs attended the education related to abuse and neglect investigation and mandatory reporting. The GM verified that one RPN's name was not highlighted as attending the mandatory education because the RPN was on sick leave for four months and had not received the mandatory education upon their return. Also, a second RPN's name was not highlighted as attending the mandatory education. The GM stated the RPN was a casual RPN and had worked multiple shifts and should have completed the education.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was isolated. The home had a level 4 compliance history since despite Ministry of Health (MOH) action non-compliance (NC) continues with original area of NC with this section of the LTCHA that included:
• October 6, 2015: Voluntary Plan of Correction (VPC) during Complaint inspection #2015_262523_0026.
• October 6, 2015: Voluntary Plan of Correction (VPC) during Critical Incident (CI) inspection # 2015_262523_0027.
• January 18, 2018: CO #001 issued February 6, 2018 with compliance due date April 6,

2018 during CI inspection #2018_262630_0004. [s. 20. (1)]

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) related to a resident not receiving an ordered medication for several months. The error was discovered by the home after a chart audit. According to the CIS, the resident was to receive the the medication on average about 20 times per month.

A review of Remedy’s Rx pharmacy’s policy # 5.1 “Medication Orders – New Orders” revised March 1, 2016, stated in part “to ensure medication ordering practices comply with applicable legislation and to reduce the risk of medication incidents by accurate processing of medication orders” and “for as needed (PRN) medications, instructions include the indication for use, frequency or interval between doses and if additional doses are required, the maximum number of doses to be administrated in a specific period of time or per episode”.

A review of the home’s “Administration of Medications” policy "Tab 05-03" stated in part, “all medications will be administrated according to the Standards of Nursing Practice as outlined by the College of Nurses of Ontario”.

A review of the Remedy’s Rx Medication Incident/Near Miss Report stated that the type of incident was related to communication and medication administration and that the effect on the resident was harmful.

A review of the home’s “Prescriber Order Sheet” for the resident indicated a specific medication order with specific parameters.The order was signed by the physician and processed by the Registered Practical Nurses (RPNs).

A review of the resident’s electronic Medication Administration Record (eMAR) for a five month of period of time, included the specific medication order and the monitoring four times a day. A review of the resident’s eMAR indicated the resident was to receive the medication for a total of 204 times for the five month period of time, but did not.

During an interview, the Director of Care (DOC) verified there was an order for the medication with no frequency for the use of the medication. That the physician wrote an order with no frequency, the registered staff entered the order into the eMAR and forwarded the order to the pharmacy. The DOC added that the pharmacy entered the monitoring with no frequency. The DOC stated that they called the pharmacy and asked why they processed the order and they said “they assumed”. The DOC stated that the expectation was that registered staff would process medication orders accurately as per best practice to reduce the risk of medication incidents.

The licensee has failed to ensure that the order for the administration of a specific medication for a resident was administered to the resident in accordance with the directions for use specified by the prescriber.

B) The home submitted a CIS report to the MOHLTC that indicated a physician’s phone order was received for a specific medication. The registered staff member incorrectly wrote the phone order as milliliters (ml) rather than milligrams (mg). The resident received four doses of the medication and were sleeping more than usual and not consuming food or fluids. The CIS also stated that the “DOC and ADOC checked the resident’s profile and noted that there was an error – no medication strength was indicated in the order only fluid amount. Attending physician stated that they ordered mg, not ml”.

A review of the home’s Medication Incident/Near Miss Report stated that the type of incident was related to communication, medication administration, and documentation and that the effect on the resident was harmful.

The Registered Nurse (RN) and RPN stated that the physician’s orders would be reviewed and if a discrepancy was identified, they would call the physician to clarify.

During an interview, the DOC stated that an incorrect strength was forwarded to the pharmacy and the pharmacy assumed the medication in milligrams was to be administered and processed the error. The DOC stated that the expectation was that registered staff would process medication orders accurately as per best practice to reduce the risk of medication incidents.

The licensee has failed to ensure that the order for the administration of a medication to the resident was administered to the resident in accordance with the directions for use specified by the prescriber.

The severity of this issue was determined to be a level 3 as there was actual harm/risk. The scope of the issue was a pattern. The home had a level 4 compliance history since despite Ministry of Health (MOH) action non-compliance (NC) continues with original area of NC with this section of the LTCHA that included:
• November 24, 2015: Voluntary Plan of Correction (VPC) during Complaint inspection #2015_183128_0023.
• March 14, 2016 2016: VPC during Resident Quality Inspection #2016_262523_0016.
• June 20, 2017: VPC during Critical Incident System inspection #2017_263524_0018.
[s. 131. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: 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 plan of care was based on the assessment of the resident and the resident’s needs and preferences.

During stage one of the Resident Quality Inspection (RQI), a resident’s family member stated that the resident did not receive the assistance with toileting that they needed.

The resident’s care plan stated the resident required assistance and a progress note in Point Click Care (PCC) stated that the resident required assistance for toileting and was agreeable to using an incontinence product.

The Continence Evaluation SV2 – V1 assessment in PCC documented the resident incontinent of bowel.

A Personal Support Worker (PSW) stated the resident was a one person transfer and was considered mobile in terms of their toileting routine.The PSW stated that the resident was incontinent and the resident was provided with an incontinence product and would receive assistance if requested, but if not, would be supervised. The PSW reviewed the resident's care plan in PCC and stated that the care plan was not updated with the current bowel continence status of the resident. The PSW reviewed the most recent Continence Evaluation assessment in PCC and the PSW confirmed that the assessment stated the resident was incontinent of bowels. The PSW stated that the resident was incontinent as per the assessment and was provided with a product. The PSW verified that the resident was assessed as incontinent in the assessment and this was to be reflected in their care plan.

The home’s policy titled “Continence”, Tab 04-29, stated, “the resident’s continence will be reassessed annually and as needed (PRN) using the Continence Assessment Tool,

with care plan update included.”

The licensee has failed to ensure that the plan of care was based on an assessment of the resident's needs and preferences. [s. 6. (2)]

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

The resident approached the Inspector and shared that staff were not regularly checking the resident’s specific therapeutic intervention. With the resident’s permission, the Inspector shared this information with the Director of Care (DOC) who said they would follow up with the concern.

Record review for the resident identified orders for the specific therapeutic intervention to be checked every shift.

The resident again approached the Inspector and asked to check specific therapeutic intervention. The Inspector requested the Assistant Director of Care (ADOC) to check the resident’s specific therapeutic intervention and the ADOC verified that it was not in use.

The Registered Practical Nurse (RPN) verified that the resident required a specific measurement for the specific therapeutic intervention. The RPN stated that registered staff were required to check if the resident was getting the ordered specific therapeutic intervention three times a day for each shift.

The licensee failed to ensure that the resident received the specific therapeutic intervention as specified in the plan of care. [s. 6. (7)]

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 plan of care is based on the assessment of the resident and the resident’s needs and preferences, to be implemented voluntarily.

WN #5: 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 failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

A Critical incident System (CIS) report related to physical abuse towards a resident was submitted to the Director of the Ministry of Health and Long Term Care (MOHLTC).

A request was made by the Centralized Intake Assessment and Triage Team (CIATT) for the home to amend the CIS to include actions taken by police, and include specific strategies and actions planned to prevent recurrence.

Review of the Ministry's Compliance Smart Client (CSC) system, as well as the Long Term Care website failed to show any amendments made to the CIS.

The General Manager (GM) verified there were no amendments submitted to the MOHLTC for the CIS that included the progress and outcome of the investigations, actions taken by police, long-term actions the home has taken to protect the resident from abuse, and specific strategies and actions to prevent recurrence.

The licensee did not ensure that the results of the abuse investigation for the CIS were reported to the Director as per the legislative requirements. [s. 23. (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 the results of the abuse or neglect investigation are reported to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).
(e) continence care products are not used as an alternative to providing assistance to a person to toilet; O. Reg. 79/10, s. 51 (2).
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,

(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented and each resident who was incontinent and had been assessed as being potentially continent or continent some of the time received the assistance and support from staff to become continent or continent some of the time.

During stage one of the Resident Quality Inspection (RQI) in a resident's room, multiple soiled clothing garments were observed. The same soiled garment was observed on the floor the next day.

The home's Continence policy tab 04-29 stated in part, "For residents who are incontinent, the Voiding & Bowel Elimination Record may be used to determine patterns over a 2-day period. The results of these assessments will be used by the interprofessional team to create a plan of action and an individualized care plan."

The resident's last continence assessment stated the resident was incontinent of urine and continent of bowels. The resident's current care plan for continence stated that they were continent of bladder and bowels.

The Registered Practical Nurse (RPN) and Personal Support Worker (PSW) said that the resident was continent, but on review of the resident's last continence assessment, they

agreed that the resident was incontinent of urine, that it was not care planned and that no interventions had been attempted to promote continence.

The DOC also observed the soiled garment on the resident's floor in the resident’s room and agreed that the resident was incontinent some of the time and that the resident's bladder incontinence had not been addressed, no interventions were in place and implemented and that no assistance or support had been provided to become continent. [s. 51. (2)]

2. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence and each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A resident was admitted to the Long Term Care home. On Admission the "Move In Assessment Admission Details” documented as part of the progress note in Point Click Care (PCC) stated the resident was continent of urine.

The Point of Care (POC) documentation by PSWs in PCC for “Support Action: Activity of Daily Living (ADL) - Continence Bowel and Bladder” with a look back period of 14 days was documented as incontinent of bladder for seven of the 38 entries or 18 per cent of the time.

The "Continence Evaluation - SV2 - V 1" assessment in PCC stated the resident was continent of urine and bowels.

The Minimum Data Set (MDS) Assessments in PCC documented the following for section H: Bladder Continence in last 14 days documented a decline in bladder continence.

The current care plan in PCC documented a focus related to bladder function where the goal for the resident was to “maintain continent through the review date” and that the resident was continent of bladder and independent. The care plan did not identify an intervention related to product use.

The General Manager (GM) and the Inspector referred to and reviewed the PCC assessments, care plan and MDS assessments for the resident. The GM verified that the last Continence Evaluation assessment indicated that the resident was continent of bladder on admission. The GM also verified that the MDS assessment completed on admission documented the resident as continent of bladder. The GM acknowledged that the resident had a decline in bladder continence as indicated on two subsequent Quarterly MDS assessment where the resident was documented as occasionally incontinent of bladder. The GM stated that the "Continence Evaluation - SV2 - V 1" assessment in PCC had been retired and that the staff now use the "Continence Evaluation - SV2 - V2" assessment, but that one was not completed for the resident when there was a decline in bladder continence identified in the MDS assessments. The GM acknowledged that the resident was also documented to use "Pads or briefs used" in all three MDS assessments completed since admission and that the care plan in PCC stated "Continent of Bladder” with no interventions related to the use of an incontinent product.

The resident stated that they used a product used to manage their incontinence. The resident stated that they were incontinent of bladder but were able to independently change their incontinence product.

The Neighbourhood Coordinator, and two PSWs shared that they knew the resident was incontinent of urine because the day shift PSWs would find a wet incontinent products in the resident's room; but that the resident was otherwise independent with toileting and continence care routines.

The Schlegel Villages Continence policy tab 04-29 stated, "The resident's continence will be reassessed annually and as needed (PRN) using the Continence Assessment Tool, with care plan updated included."

The licensee failed to ensure that the resident who was occasionally incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and as part of the resident’s plan of care to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented. [s. 51. (2)]

3. The licensee failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition

or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The Minimum Data Set (MDS) admission assessment indicated the resident had a bladder continence status of usually continent, and a quarterly MDS assessment indicated that the resident had a bladder continence status of occasionally incontinent.

The Continence Evaluation assessment in Point Click Care (PCC) indicated that the resident was continent of urine.

The resident’s care plan in PCC stated the resident was "Incontinent of bladder".

The resident stated that they used an incontinence product.

The Registered Nurse (RN) stated that the Continence Evaluation was the assessment tool used to assess bladder continence and was completed by registered staff or personal support workers. The RN stated that the MDS was completed by registered staff on admission and the Continence Evaluation assessment would be completed and was reflective of the residents' MDS assessment and care plan. The RN reviewed the MDS admission assessment for the resident, and stated the resident was determined to be usually continent and stated that this was based on the Continence Evaluation on admission. The RN reviewed the Continence Evaluation assessment and verified that the resident was assessed to be continent. The RN reviewed the care plan for bladder continence in PCC and verified that the bladder continence section stated the resident was incontinent. The Inspector asked if the RN expected that the care plan was to be reflective of the assessment, and the RN stated "yes". The RN stated that the resident's care plan was not reflective of the Continence Evaluation assessment.

The Schlegel Villages Continence policy tab 04-29 stated, “Upon move-in, each resident will have a Continence Assessment using the RAI MDS tool in combination with a resident specific assessment. Non-PCC Villages will use the Bowel & Bladder Assessment Form attached to the policy. Villages using PCC will use the online assessment, named Continence. The RAI-MDS assessment will include a 7-day observation period. For residents who are incontinent, the Voiding & Bowel Elimination Record (attached) may be used to determine patterns over a 2-day period. The results of these assessments will be used by the interprofessional team to create a plan of action and an individualized care plan.”

The licensee failed to ensure that the resident who was incontinent, received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

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, each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; and each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other; written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours; resident monitoring and internal reporting protocols and protocols for the referral of residents to specialized resources were developed to meet the needs of residents with responsive behaviours.

The "Spa (shower, Tub Bath, Sponge Bath)" policy tab 04-06 stated in part, "Bath/shower refusal - When a resident declines their spa after multiple attempts and negotiation, it must be documented on the PSW paper flow sheet under 'Bathing' as well as in the 'Personal Expressions' section, or in the appropriate Bathing and Personal Expressions sections of the electronic health record if village is paper free. The PSW will report this refusal to the team leader and the team leader will document the reason for refusal and alternative interventions tried without success. If resident refuses today, offer their spa the following day, or later in the shift".

The resident’s current care plan indicated that the resident was independent for care. There were no behaviours (personal expressions) indicated in the care plan of the resident.

Over the course of several days, the resident was observed wearing soiled clothing and

their hair appeared not cleaned.

A review of the home's "Follow Up Question Report" over the course of six months indicated that the resident refused or had not received a bath 22 times.

The RPN and PSW said that the resident was refusing baths/showers and not changing clothes occasionally and that it was “personal expressions” and would expect to have them assessed and interventions in place.

The DOC said that there was no documentation noted related to bath refusal for the resident as per the home’s policy. The DOC agreed that a resident refusing bath/showers consistently and not caring for themselves were personal expressions and that the resident should have been assessed so that interventions could be put in place for the resident.

The licensee had failed to ensure that written approaches to care and identification of behavioural triggers that resulted in responsive behaviours where the resident was refusing baths, and interventions to respond to the responsive behaviours, as well as monitoring the resident, their bathing needs and refusal of care, and the referral to specialized resources were developed to meet the resident's needs. [s. 53. (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 the following are developed to meet the needs of residents with responsive behaviours: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. 3. Resident monitoring and internal reporting protocols. 4. Protocols for the referral of residents to specialized resources where required., to be implemented voluntarily.

WN #8: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

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:
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. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any 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. 107 (4).
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).
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. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), 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. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of resident who was missing for three hours or more.

A Critical Incident System (CIS) report submitted to the Ministry of Health and Long Term Care (MOHLTC) documented a resident was missing greater than three hours and had a previous history of elopement on four other dates.

The progress notes in Point Click Care (PCC) were reviewed for a specific month and documented multiple elopements. The General Manager (GM) verified that the resident was missing from the home for greater than three hours. There was no chart note how the resident returned, where the resident was or what the resident was doing. The GM also stated that on a separate date where the resident was out of the building for approximately 24 hours. The GM verified that a CIS report should have been submitted to the MOHLTC for the incident on these two dates when the resident was missing from the home for greater than three hours and for both of those dates the resident did not sign out and staff did not know where the resident was.

The licensee failed to ensure that the Director was immediately informed, in as much detail as was possible, the circumstances of the resident who was missing for three hours or more on two separate dates. [s. 107. (1) 3.]

2. The licensee failed to inform the Director of an incident under subsection (1), (3) or (3.1) 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 a description of the incident, including the date and time of the incident and the analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

A) A Critical Incident System (CIS) report for a resident documented the resident was

missing greater than three hours. The CIS report under the "Analysis and Follow-up" section documented that the long term actions to correct this situation where "pending outcome of investigation".

The General Manager (GM) verified that the CIS report was not amended with the long-term actions planned to correct this situation where the resident was missing greater than three hours and the CIS should have been amended that the resident was still receiving one on one staff supervision since the time of the resident's elopement.

B) A Critical Incident System (CIS) report for a resident documented the resident was missing greater than three hours. The CIS report under the "Analysis and Follow-up" section documented an immediate action where an "emergency care conference to be planned regarding recurrent incidents" to prevent recurrence. The long term actions to correct this situation stated, "pending results of care conference". Under the "General Notes" section the home was asked to amend the CIS report to include, "long term strategies and/or interventions planned to prevent recurrence." A month later the home was asked again to amend the CIS report to include this information. The "Current Status" of the CIS report stated the incident was submitted with no amendments.

The GM verified that CIS report was not amended with the long-term actions planned to correct this situation where the resident was missing greater than three hours. The CIS should have been updated with the results of the emergency care conference and the plan in place for the resident and that the CIS should have been amended when the home received a reminder from the Centralized Intake Assessment and Triage Team (CIATT) on two separate dates.

C) A Critical Incident System (CIS) report for a resident documented the resident was missing greater than three hours. The critical incident date and time stated it occurred on a specific date.

The GM verified that the CIS report did not document the correct date when the resident was missing greater than 3 hours and acknowledged that the CIS report for the date of the incident was documented incorrectly.

The licensee failed inform the Director in writing the correct date and time for as part of the CIS report, and the immediate and long-term actions planned to correct the situation and prevent recurrence. [s. 107. (4)]

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 Director is immediately informed, in as much detail as is possible in the circumstances, of resident who was missing for three hours or more, and to inform the Director of an incident under subsection (1), (3) or (3.1) 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: the date and time of the incident and analysis and follow-up actions including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents was fully respected and promoted: Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

In the Westminister Neighborhood, a Registered Nurse (RN) was observed walking away from the medication cart with the Point Click Care (PCC) screen showing personal health information for a resident. As well, a resident's empty medication package was laying on top of a plastic container on the medication cart with personal health information related to medication administration.

Eight residents, a housekeeper, and a private care volunteer passing by were observed within reach of the medication cart.

A review of the home's "Confidentiality of Information" policy tab 04-05 stated, "Schlegel Villages and its team members will comply with the requirements of the Personal Health Information Protection Act and any other applicable legislation and regulations".

The RN returned to the medication cart twelve minutes later and verified that the PCC screen was left on with the resident's personal health information and another resident's medication package in plain view. The RN stated that they usually turn off the PCC screen and that a lid should be provided to hide the resident's personal health information on the medication packages.

The DOC stated that it was the home's expectation that staff members protected the residents' personal health information. [s. 3. (1) 11. iv.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was dressed appropriately in their own clean clothing and appropriate clean footwear.

A resident was observed in their room wearing soiled clothing and the resident's hair did not appear to be clean. In the resident's room, soiled garments were observed on the floor.

The resident was observed again the next day by two Inspectors wearing soiled clothing, resident's hair did not appear to be washed, and bed linens were also observed soiled.

The resident was observed again on another day sitting in dining room of the Westminister Neighbourhood wearing soiled clothing and their hair appeared not clean. Furthermore, the same soiled garment was observed on the floor.

Again, the resident was observed sitting on their bed wearing soiled clothing with holes in it and hair appeared not clean. Furthermore, the same soiled garment was observed on the floor for a consecutive third day.

The Registered Practical Nurse (RPN) and Personal Support Worker (PSW) stated that PSWs collected soiled clothes daily for laundry and that housekeepers were cleaning the residents room floors daily.

The Director of Care (DOC) observed the resident's room and agreed that the resident's clothes in their closet and the clothes laying around the room were soiled, a soiled garment was on the floor, bed linens were soiled and that the resident was wearing soiled clothing and soiled running shoes with a hole in them. The DOC stated that it was expected that the staff make sure residents' clothes were kept clean and they were dressed appropriately in their own clean clothing and appropriate clean footwear. [s. 40.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to provide training related to continence care and bowel management to all staff who provide direct care to residents on an annual basis.

The online Market Place report outlining the completion records for the nursing team members related to continence education for 2017 documented that multiple staff members did not complete the education required.

The Neighbourhood Coordinator (NC) stated there were 250 nursing team members in 2017 and only 199 team members completed the education related to continence. The NC verified that 51 nursing team members either did not complete the education related to continence, or was unsuccessful, the modules were still in progress or the team member was simply enrolled without completion. The NC stated that the 51 nursing team members should have completed the continence education as part of the mandatory education annually. The NC also verified that 79.6 per cent completed the education in 2017 related to continence and the expectation was that 100 per cent of the nursing team was to complete the training in 2017.

The licensee has failed to provide training related to continence care and bowel management to all staff who provide direct care to residents on an annual basis in 2017. [s. 221. (1) 3.]

Issued on this 26th day of September, 2018

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

Original report signed by the inspector.

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) :	MELANIE NORTHEY (563), CASSANDRA ALEKSIC (689), DONNA TIERNEY (569), HELENE DESABRAIS (615)
Inspection No. / No de l'inspection :	2018_606563_0013
Log No. / No de registre :	014846-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 14, 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
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cindy Awde

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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. 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).

Order / Ordre :

The licensee must be compliant with s. 19(1) of the LTCHA.

Specifically, the licensee shall ensure that:
a) Registered Practical Nurse (RPN) #160 and RPN #161 will receive education related to Remedy's Rx Emergency Stock Box Policy Number 3.9 last revised March 1, 2016.
b) RPN #160 and RPN #161 will ensure medication ordering practices comply with applicable legislation and Remedy's Rx New Orders Policy Number 5.1 last revised March 1, 2016.

Grounds / Motifs :

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

Section 2(1) of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

A Critical Incident System (CIS) report documented improper treatment of a resident. The CIS stated nursing measures were provided, a specific medication was ordered by the Nurse Practitioner and sample was to be sent for analysis. The medication order was not processed by the day the Registered Practical Nurse (RPN) or evening the RPN and a sample was not collected. The first dose of medication was administered in the morning of the next day. The resident's physician was contacted as the resident was exhibiting acute medical symptoms and was transferred to acute care.

The progress notes in Point Click Care (PCC) for the resident documented ongoing symptoms of an acute medical condition, the late administration of a specific medication, a sample was ordered by the Nurse Practitioner but was not taken.

The home's investigation notes documented an interview by the on-call manager, the Director of Environmental Services (DES) and the RPN and stated that the medication order was not processed and there was no first and second check by the registered staff and "that's neglect/incompetence from us, it's a big deal with the Ministry". The RPN verified the medication was not administered to the resident on time.

The electronic Medication Administration Record (eMAR) in PCC for the resident documented that the first documented dose was given late.

The RPN stated if a resident received an order for a specific medication, the order was to be processed using a digipen and sent to pharmacy. The RPN added that in the meantime, the registered staff would go to contingency, get the medication, start the dose and document this in the eMAR. The RPN was the staff member working the day shift and shared that the resident was administered the specific medication late.

The Assistant Director of Care (ADOC) stated they became aware of the critical incident when the on-call manager, the DES, brought it forward during the leadership huddle the next day and the DES stated they had already initiated the CIS and submission to the MOHLTC related to the improper/incompetent treatment of the resident. The ADOC verified that the day the RPN did not pass on the information regarding the resident's medication order to the oncoming evening RPN and did not process the order and it was a high risk medication order. The ADOC also stated that a higher alert medication order can be put in PCC by the nurse and the medication can be retrieved from the contingency box and this did not happen related to the resident's specific medication order. The ADOC stated the contingency box was the emergency stock medications kept in the home, but that the registered staff also have access to the on-call pharmacy for those medications not available but need to be started, and the medications would be dispatched right away. The ADOC verified that the order for the medication was received on and the first dose was administered the following day. The ADOC stated neglect was failure to provide the expected level of care

or services to the resident and acknowledged that the incident involving the resident met the definition of neglect as stated in the Long Term Care Homes Act. The ADOC also acknowledged that there was a breakdown in communication that led to the omission of a high alert medication to be administered to the resident; and the emergency stock medications were not utilized to ensure the resident received the medication required for health and well being.

The Remedy's Rx Emergency Stock Box Policy Number 3.9 last revised March 1, 2016, stated the emergency stock box was available to provide an emergency supply of medications allows registered staff to begin medication therapy upon receipt of a prescriber's order to prevent any delay in treatment.

The licensee failed to ensure that the resident was free from neglect by the licensee or staff in the home. The resident's status had deteriorated and the resident was assessed by the Nurse Practitioner (NP). At that time, the NP ordered a sample for analysis and a specific medication, but the medication was not administered until the next day. The day RPN and the evening RPN did not ensure the order was processed and that the medication was received from pharmacy. The registered staff did not obtain the medication from contingency to administer it. Although a progress note documented that a sample could have been obtained as ordered, it was not. The resident was transferred to acute care.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was isolated. The home had a level 4 compliance history since despite Ministry of Health (MOH) action non-compliance (NC) continues with original area of NC with this section of the LTCHA that included:
• October 6, 2015: Voluntary Plan of Correction (VPC) during Complaint inspection #2015_262523_0026.
• March 14, 2016: Compliance Order (CO) #004 was issued May 12, 2016 with compliance due date May 31, 2016 during Resident Quality Inspection (RQI) #2016_262523_0016 and was closed with a link on July 11, 2016.
• June 28, 2016: CO #003 and linked to CO #004 was issued July 27, 2016 with compliance due date August 31, 2016 during Follow Up inspection #2016_262523_0026 and was complied September 30, 2016.
• January 31, 2017: VPC during Complaint inspection 32017_538144_0009.
• April 13, 2017: CO #001 issued September 12, 2017 with compliance due date October 31, 2017 during RQI #2017_607523_0007 and was complied February

2, 2018.
• June 19, 2017: VPC during Complaint inspection #2017_263524_0017.
• June 20, 2017: VPC during Critical Incident (CI) inspection #2017_263524_0018.
• January 18, 2018: Written Notification (WN) during CI inspection #2018_262630_0004 as further evidence to support CO #001 from RQI #2017_607523_0007. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2018_262630_0004, CO #001;

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 must be compliant with s. 20 (1) of the LTCHA.

Specifically, the licensee shall ensure that:
a) Ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with, specific to but not limited to the immediate reporting of the allegation of abuse or neglect to any supervisor including the charge nurse or any member of the leadership team, and
b) Registered Practical Nurse (RPN) #156, RPN #158, RPN #159 and Registered Nurse #157 are to be re-educated on the home's "Prevention of Abuse and Neglect" policy related to the required reporting of any suspicions, incidents, or allegations of neglect and/or abuse immediately to any supervisor including the charge nurse or any member of the leadership team for further investigation.

Grounds / Motifs :

1. The licensee failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

The Schlegel Villages Code of Conduct Prevention of Abuse and Neglect Policy Tab 04-06 stated, “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 to follow Section 24 – Mandatory Reports. [LTC Act s. 24].” “All team members, students

and volunteers who witness or suspect the abuse of a resident, or receive complaints of abuse, are required to report the matter immediately to any supervisor including the charge nurse, or any member of the leadership team." The policy documented "lack of privacy" and "ignoring resident, or a request for assistance" as a form of emotional abuse.

A resident was interviewed during stage "1" of the Resident Quality Inspection. The Inspector asked the question, "Do you feel the staff treats you with respect and dignity? For example, do staff take the time to listen to you and are staff helpful when you request assistance?" and the resident answered "no". The resident stated there was a specific time during care when they felt staff were not providing the help they needed. The resident then showed the Inspector a typed note and stated the nurse on the night shift typed it for them from their handwritten notes. The resident stated they were going to report the recent incident to the Director of Care (DOC) today because this should have never happened.

The letter typed by the RPN for resident documented the incident occurred. The letter documented that the resident felt belittled, discouraged, humiliated, and degraded.

The home submitted the written complaint by the resident to the Ministry of Health and Long-Term Care (MOHLTC) related to allegations of staff to resident abuse or neglect and the incident was immediately investigated where the allegations were unfounded. However, over the course of the inspection it was identified through interviews and 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 immediate reporting of alleged staff to resident abuse or neglect.

The licensee failed to ensure that the Schlegel Villages Code of Conduct Prevention of Abuse and Neglect Policy Tab 04-06 was complied with. The policy promoted zero tolerance of abuse and neglect of residents and stated "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." The RPN wrote a progress note documenting the resident's conversation with a table mate related to the incident and did not report this to the Charge Nurse or a member of the leadership team. A second RPN was made aware of the allegation of staff to resident abuse when

they typed the resident's letter to the DOC and did not report the allegation immediately to the leadership team. The RN who was the charge nurse stated having no knowledge of the allegations of abuse until the end of their shift. The RN was uncertain if they reported this to the DOC. The resident was the one who reported the allegation to the DOC.

The Village of Glendale Crossing were required to comply with Compliance Order (CO) #001 related to "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." CO #001 was to be complied. Specifically the licensee was to 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.

The General Manager (GM) verified that charge nurses and leadership team members were educated as documented in the CO #001. The GM stated that the home also educated the RPNs and verified that the RPNs were the team leads for the neighbourhoods. The Inspector and the GM reviewed of the education attendance and the GM stated that those staff whose names were highlighted green on the "Schedule Worksheet" for RNs and RPNs attended the education related to abuse and neglect investigation and mandatory reporting. The GM verified that one RPN's name was not highlighted as attending the mandatory education because the RPN was on sick leave for four months and had not received the mandatory education upon their return. Also, a second RPN's name was not highlighted as attending the mandatory education. The GM stated the RPN was a casual RPN and had worked multiple shifts and should have completed the education.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was isolated. The

home had a level 4 compliance history since despite Ministry of Health (MOH) action non-compliance (NC) continues with original area of NC with this section of the LTCHA that included:
• October 6, 2015: Voluntary Plan of Correction (VPC) during Complaint inspection #2015_262523_0026.
• October 6, 2015: Voluntary Plan of Correction (VPC) during Critical Incident (CI) inspection # 2015_262523_0027.
• January 18, 2018: CO #001 issued February 6, 2018 with compliance due date April 6, 2018 during CI inspection #2018_262630_0004. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with Ontario Regulation r. 131(2).
Specifically, the licensee shall ensure that:
a) Resident #025 and any other resident will receive the Peripheral Blood Glucose (PBG) monitoring as ordered and the sliding scale insulin will be administered according to the PBG results.
b) Resident #026 and any other resident's medication orders will be processed and documented accurately.
c) All registered nursing staff will receive education on Remedy's Rx pharmacy's "Medication Orders-New Orders" Policy Number 5.1 related to the accurate processing of medication orders.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) related to a resident not receiving an ordered medication for several months. The error was discovered by the home after a chart audit. According to the CIS, the resident was to receive the the medication on average about 20 times per month.

A review of Remedy's Rx pharmacy's policy # 5.1 "Medication Orders – New Orders" revised March 1, 2016, stated in part "to ensure medication ordering practices comply with applicable legislation and to reduce the risk of medication incidents by accurate processing of medication orders" and "for as needed (PRN) medications, instructions include the indication for use, frequency or interval between doses and if additional doses are required, the maximum

number of doses to be administrated in a specific period of time or per episode".

A review of the home's "Administration of Medications" policy "Tab 05-03" stated in part, "all medications will be administrated according to the Standards of Nursing Practice as outlined by the College of Nurses of Ontario".

A review of the Remedy's Rx Medication Incident/Near Miss Report stated that the type of incident was related to communication and medication administration and that the effect on the resident was harmful.

A review of the home's "Prescriber Order Sheet" for the resident indicated a specific medication order with specific parameters.The order was signed by the physician and processed by the Registered Practical Nurses (RPNs).

A review of the resident's electronic Medication Administration Record (eMAR) for a five month of period of time, included the specific medication order and the monitoring four times a day. A review of the resident's eMAR indicated the resident was to receive the medication for a total of 204 times for the five month period of time, but did not.

During an interview, the Director of Care (DOC) verified there was an order for the medication with no frequency for the use of the medication. That the physician wrote an order with no frequency, the registered staff entered the order into the eMAR and forwarded the order to the pharmacy. The DOC added that the pharmacy entered the monitoring with no frequency. The DOC stated that they called the pharmacy and asked why they processed the order and they said "they assumed". The DOC stated that the expectation was that registered staff would process medication orders accurately as per best practice to reduce the risk of medication incidents.

The licensee has failed to ensure that the order for the administration of a specific medication for a resident was administered to the resident in accordance with the directions for use specified by the prescriber.

B) The home submitted a CIS report to the MOHLTC that indicated a physician's phone order was received for a specific medication. The registered staff member incorrectly wrote the phone order as milliliters (ml) rather than milligrams (mg). The resident received four doses of the medication and were sleeping more than usual and not consuming food or fluids. The CIS also stated that the "DOC and

ADOC checked the resident's profile and noted that there was an error – no medication strength was indicated in the order only fluid amount. Attending physician stated that they ordered mg, not ml".

A review of the home's Medication Incident/Near Miss Report stated that the type of incident was related to communication, medication administration, and documentation and that the effect on the resident was harmful.

The Registered Nurse (RN) and RPN stated that the physician's orders would be reviewed and if a discrepancy was identified, they would call the physician to clarify.

During an interview, the DOC stated that an incorrect strength was forwarded to the pharmacy and the pharmacy assumed the medication in milligrams was to be administered and processed the error. The DOC stated that the expectation was that registered staff would process medication orders accurately as per best practice to reduce the risk of medication incidents.

The licensee has failed to ensure that the order for the administration of a medication to the resident was administered to the resident in accordance with the directions for use specified by the prescriber.

The severity of this issue was determined to be a level 3 as there was actual harm/risk. The scope of the issue was a pattern. The home had a level 4 compliance history since despite Ministry of Health (MOH) action non-compliance (NC) continues with original area of NC with this section of the LTCHA that included:
• November 24, 2015: Voluntary Plan of Correction (VPC) during Complaint inspection #2015_183128_0023.
• March 14, 2016 2016: VPC during Resident Quality Inspection #2016_262523_0016.
• June 20, 2017: VPC during Critical Incident System inspection #2017_263524_0018. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 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 14th day of September, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Melanie Northey

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