Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 25, 2019	2019_778563_0039	016222-19, 019402-19	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

MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 15, 16, 17 and 18, 2019

The following Critical Incident System (CIS) intakes were completed within this inspection:
Log #016222-19 for CIS #2979-000076-19 related to staff to resident abuse
Log #019420-19 for CIS #2979-000087-19 related to staff to resident abuse

The following Complaint intake was completed within this inspection:
- Log #018681-19 for Complaint #IL-70619-LO related to staff to resident abuse
- Related to CIS #2979-000087-19

During the course of the inspection, the inspector(s) spoke with the General Manager, the Acting Assistant Director of Nursing Care, the Neighbourhood Coordinators, Registered Practical Nurses, Personal Support Workers and residents.

The inspector(s) also made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) A Critical Incident System (CIS) documented an incident of staff to resident abuse. The CIS was submitted to the Ministry of Health and Long Term Care (MOHLTC) through the INFOLINE – Long Term Care Homes After Hours on the same day.

The Ministry of Health and Long Term Care INFOLINE - Complaint Information Report documented that an anonymous caller reported a specific incident involving one Personal Support Worker (PSW).

An email correspondence was sent from a PSW to the Neighbourhood Coordinator describing the incident.

A handwritten conversation between the Neighbourhood Coordinator and the PSW documented the reported incident involving the accused PSW and the resident to an Agency Registered Practical Nurse (RPN) on the day of the incident. The PSW also stated the accused PSW ignored the call bells of a different resident and could be very rude to some residents, including another resident specifically.

The Neighbourhood Coordinator (NC) verified the incident involving the resident occurred on a specific date, and not on the date as documented as part of the CIS Report. The NC stated they were made aware of the incident by email from a PSW several days after the incident. The NC stated the PSW who witnessed the suspected abuse towards the resident reported it to a PSW only and not to a member of the registered nursing team. The NC stated the resident's plan of care included interventions related to the resident's behaviours. The NC acknowledged there were three other residents mentioned as part of the investigation interviews with two PSWs. At that time of the investigation, the three residents were not interviewed and other residents in the neighbourhood were not interviewed as part of the investigation into allegations of "rough and rude" care provided by the accused PSW. The NC stated there were very vocal and cognitively intact residents in the neighbourhood that would have reported if care was rough and there were no reported concerns related to the accused PSW at any time. The NC also verified that the agency RPN did not report the alleged incident related to the resident to anyone when they were made aware of it. The agency RPN has not worked another shift in the home since that time.

The licensee has failed to ensure that the written policy that promoted zero tolerance of

abuse and neglect of the resident was complied with. The PSW did not report the suspected abuse the day it happened and when it was witnessed during the care of the resident. Another PSW reported the allegations of suspected abuse towards the resident to the Agency RPN days later and the Agency RPN did not report it to the nursing management team. The same PSW did not report the allegations of abuse to the nursing management team before the email to the Neighbourhood Coordinator several days after that.

b) A Critical Incident System (CIS) Report documented an incident of staff to resident abuse. The CIS was first submitted to the Ministry of Health and Long Term Care (MOHLTC) almost a month late.

The home's investigation notes included an interview with the Personal Support Workers (PSWs) who provided care to the resident on a particular date. The Schlegel Villages Interval Incident Report documented the allegations found to be untrue. The resident was confusing their product change at night, had become aggressive towards team members when giving care at night.

The General Manager (GM) and the Neighbourhood Coordinator (NC) were interviewed. The NC stated on the morning of the incident, they read a progress note detailing the resident's reported accusation of staff to resident abuse. The NC completed an internal incident report, interviewed the resident and a referral to Personal Expressions Resource Team (PERT) was made that same day. There were no reasonable grounds to suspect there was any abuse towards the resident. The GM stated the PERT referral was sent and because there was a transition from the previous PERT Lead to when the new PERT Lead started, the outstanding referral was reviewed and taken to the Nurse Consultant who requested submission to the MOHLTC. The NC stated the home followed the abuse decision tree and the incident was investigated internally and they were confident there was no assault based on the accused PSW was never alone with the resident, the resident's personal expressions and confusion. The GM stated the mandatory reporting requirements related to allegations of abuse include immediate reporting to the MOHLTC. The allegation would be reported to the Registered Nurse (RN) and the RN would then report to the on call manager. The GM stated the RN would also call it in to the after hours line for the MOHLTC and to the on call manager. The GM stated they were notified of the allegation related to the resident during an operational planning meeting off site by the Nurse Consultant and the GM initiated the CIS report a month late after the Nurse Consultant completed their interview with the resident. The GM verified the registered staff did not report the allegation of abuse to management and the CIS

was submitted very late.

The resident stated the staff have never treated them roughly, have never yelled at or have been rude during care and did not recall the incident of abuse during the conversation.

The Schlegel Villages 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 the Director as well as any supervisor or any member of the leadership team for further investigation." The duty to report abuse or suspected abuse included, "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 the Director and any supervisor including the charge nurse, or any member of the leadership team."

The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of the resident was complied with. The progress notes documented the resident had reported similar reports of abuse the week prior. There was no report to the nursing management team at that time. The General Manager was not informed of the allegation of abuse and the information upon which it was based until several weeks later. At that time the CIS report was initiated late upon the recommendation of the Nurse Consultant. [s. 20. (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 written policy that promoted zero tolerance of abuse and neglect of residents is complied with., 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 has failed to 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: the date and time of the incident, a description of the individuals involved in the incident including names of all residents

involved in the incident; and names of any staff members or other persons who were present at, discovered or were responding to the incident; 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.

A Critical Incident System (CIS) Report documented an incident of staff to resident physical abuse. The CIS was submitted to the Ministry of Health and Long Term Care (MOHLTC) through the INFOLINE – Long Term Care (LTC) Homes After Hours the same day.

An email correspondence was sent from a PSW to the Neighbourhood Coordinator describing the incident as well as mentioning other allegations towards three other residents.

A handwritten conversation between the Neighbourhood Coordinator and the PSW documented the reported the incident involving another PSW and the resident to an Agency Registered Practical Nurse (RPN) on the day of the incident. The PSW also stated the accused PSW ignored the call bells of a different resident and could be very rude to some residents, including another resident specifically.

The home's investigation notes included a handwritten interview with the PSW and at that time, the PSW also reported witnessing the accused PSW arguing and threatening other residents.

The Neighbourhood Coordinator (NC) stated three other residents were not documented as part of the report to the Director and should have been.

The licensee failed to include the date and time of the incident correctly and failed to report the names of the three residents involved in the incident. The names of one PSW and the Agency RPN were absent from the report and they were responsible for reporting the incident. The person of importance or a substitute decision-maker to the three residents who were identified as part of the home's investigation were not contacted related to the allegations of suspected abuse by the accused PSW. [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 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: the date and time of the incident, a description of the individuals involved in the incident including names of all residents involved in the incident; and names of any staff members or other persons who were present at, discovered or were responding to the incident; whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident is contacted and the name of such person or persons, to be implemented voluntarily.

Issued on this 14th day of November, 2019

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

Original report signed by the inspector.