Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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130, avenue Dufferin 4ème étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 6, 2020	2020_790730_0014	019123-20, 019235-20	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

CHRISTINA LEGOUFFE (730)

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): September 28, 29, 30 and October 1 and 2, 2020.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log# 019123-20, CIS #2979-000058-20 and Log# 019235-20, CIS #2979-000059-20 were related to unexpected deaths.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), acting Director of Care (DOC), a Registered Nurse (RN), Registered Practical Nurses (RPNs), a Personal Support Worker (PSW), and a Regional Death Investigation Administrator.

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

Complaint inspection #2020_722630_0022 was completed concurrently by inspectors #630, #730, and #740.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plans of care for three residents provided clear direction for oxygen administration.

Staff documented that they saw resident #002 sitting in bed with oxygen applied. Resident #002 had a physician's order for oxygen as needed. Resident #002's order did not say when they needed oxygen. There was no further direction in resident #002's plan of care about oxygen therapy. There was no documentation to show if the resident needed oxygen applied on a day when they had it administered. There was inconsistent documentation for administration of oxygen for resident #002.

Resident #003 had an order for oxygen, but the order did not specify when it was needed. There was no further direction in the plan of care about oxygen administration for staff who provided care to resident #003. There was no oxygen saturation reading documented on a date, when oxygen was documented as administered and effective. There was inconsistent documentation for administration of oxygen for resident #003. A Registered Practical Nurse (RPN) said that the order for resident #003's oxygen did not provide clear direction for staff.

Resident #004 told inspector #730 that they used oxygen every night. They had a physician's order for oxygen. There was no order or task for resident #004 for monitoring oxygen saturation levels. There was no documentation that oxygen was administered to resident #004 within the last month. An RPN said that resident #004 used oxygen every night. They said that they had not checked the resident's oxygen saturation levels recently prior to administrating the oxygen and that they were not documenting the administration, and that they should have checked their oxygen saturation levels and documented.

The acting Director of Care (DOC) said that the written plan of care related to oxygen therapy should provide more direction for staff in addition to the order. They also said it was their expectation that staff would monitor if the treatment was effective. They said oxygen administration should be documented on the electronic Medication Administration Record (eMAR).

There was increased risk of harm to the residents as their plans of care did not provide clear direction related to oxygen administration.

Sources: Clinical records reviewed for three residents including: progress notes, orders, care plans, oxygen saturation readings, eMAR, the licensee's Respiratory Policy; and interviews with resident #004, acting DOC and other staff. [s. 6. (1) (c)]

Additional Required Actions:

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

Issued on this 6th day of October, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHRISTINA LEGOUFFE (730)
Inspection No. / No de l'inspection :	2020_790730_0014
Log No. / No de registre :	019123-20, 019235-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 6, 2020
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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 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. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with s. 6. (1) of the LTCHA.
Specifically, the licensee must:

a) Ensure that there is a written plan of care for resident #004, that sets out clear direction to staff and others who provide care to the resident related to the use of oxygen and the monitoring of oxygen saturation levels.

Grounds / Motifs :

1. The licensee has failed to ensure that the plans of care for three residents provided clear direction for oxygen administration.

Staff documented that they saw resident #002 sitting in bed with oxygen applied. Resident #002 had a physician's order for oxygen as needed. Resident #002's order did not say when they needed oxygen. There was no further direction in resident #002's plan of care about oxygen therapy. There was no documentation to show if the resident needed oxygen applied on a day when they had it administered. There was inconsistent documentation for administration of oxygen for resident #002.

Resident #003 had an order for oxygen, but the order did not specify when it was needed. There was no further direction in the plan of care about oxygen administration for staff who provided care to resident #003. There was no oxygen saturation reading documented on a date, when oxygen was documented as administered and effective. There was inconsistent

documentation for administration of oxygen for resident #003. A Registered Practical Nurse (RPN) said that the order for resident #003's oxygen did not provide clear direction for staff.

Resident #004 told inspector #730 that they used oxygen every night. They had a physician's order for oxygen. There was no order or task for resident #004 for monitoring oxygen saturation levels. There was no documentation that oxygen was administered to resident #004 within the last month. An RPN said that resident #004 used oxygen every night. They said that they had not checked the resident's oxygen saturation levels recently prior to administrating the oxygen and that they were not documenting the administration, and that they should have checked their oxygen saturation levels and documented.

The acting Director of Care (DOC) said that the written plan of care related to oxygen therapy should provide more direction for staff in addition to the order. They also said it was their expectation that staff would monitor if the treatment was effective. They said oxygen administration should be documented on the electronic Medication Administration Record (eMAR).

There was increased risk of harm to the residents as their plans of care did not provide clear direction related to oxygen administration.

Sources: Clinical records reviewed for three residents including: progress notes, orders, care plans, oxygen saturation readings, eMAR, the licensee's Respiratory Policy; and interviews with resident #004, acting DOC and other staff. [s. 6. (1) (c)]

An order was made by taking the following factors into account:

Severity: There was increased risk of harm to residents #002, #003, and #004 as their plans of care did not provide clear direction related to oxygen administration.

Scope: This issue was widespread since the plans of care of three out of three residents did not provide clear direction for oxygen administration.

Compliance History: The licensee was found to be non-compliant with s. 6 (1) of

LTCHA, 2007 in the past 36 months, and a Voluntary Plan of Correction (VPC) was issued to the home.

(730)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2020

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 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 6th day of October, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Christina Legouffe

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