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
LONDON ON N6A 5R2
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Télécopieur: (519) 873-1300

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
Nov 17, 2020	2020_722630_0029	020651-20, 021227-20	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

AMIE GIBBS-WARD (630)

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): November 4, 5 and 9, 2020.

The following Critical Incident (CI) intakes were completed within this inspection:

Log #020651-20 / CI 2979-000062-20 related to falls prevention and management.
Log #021227-20 / CI 2979-000063-20 related to medication administration.

During the course of the inspection, the inspector(s) spoke with the acting Director of Care (DOC), a Regional Coroner, a Clinical Pharmacist, a Registered Nurse (RN), Registered Practical Nurses (RPNs) and a Personal Support Worker (PSW).

The inspector also observed resident rooms and common areas, 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 and reviewed CIS reports.

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

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 O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the written policies and protocols, that were developed for the medication management system to ensure the accurate administration of drugs used in the home, were implemented for three residents in accordance with prevailing practices.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) regarding a medication error specific to palliative care medications. The management in the home and pharmacy investigated this medication error and identified that there were concerns with the communication, administration and dispensing of the order in accordance with required policies. There was risk of harm to residents in the home related to medication ordering practices not having been implemented in accordance with the home’s policies and prevailing College of Nurses of Ontario (CNO) practices.

The "Palliative Care Orders" for three residents did not include all of the required information in accordance with the home’s policy and prevailing practices. The indication for use was not included in the orders for two out of the three residents. The route of administration was not included in the orders for one out of the three residents. The name of the prescriber was not included in the orders for two out of the three residents. Documentation that it was a telephone order was not included for two out of the three residents. The three residents' electronic Medication Administration Record (eMAR) also showed prior to the palliative care orders having been implemented, multiple other medication orders did not include the indication for use.

The staff, management and pharmacist reported that due to the COVID-19 pandemic the primary mode for obtaining medication orders from physicians in the home over the past several months had been telephone orders. The home had identified concerns with the processes for obtaining and processing telephone orders and were working on improvements to reduce the risks. Based on the medication orders policy and the staff requirement to follow the best practices from the CNO, medication orders were required to include specific information and this was not a consistent practice implemented in the home.

Sources: a Critical Incident System (CIS) report; a Medication Incident Report; the home's “Medication Orders New Orders Policy” dated August 15, 2018; clinical records for the three residents including Prescriber Orders Sheets; interview with a Registered Nurse (RN) and other staff. [s. 114. (3) (a)]

Additional Required Actions:

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

Issued on this 23rd day of November, 2020

[redacted]

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) :	AMIE GIBBS-WARD (630)
Inspection No. / No de l'inspection :	2020_722630_0029
Log No. / No de registre :	020651-20, 021227-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 17, 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:

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Order / Ordre :

The licensee must be compliant with subsection 114 (3) of O. Reg. 79/10.

Specifically, the licensee must:

Ensure the home's written policies and protocols for obtaining, documenting and communicating medication orders are fully implemented for all residents with end of life care/palliative care related orders.

Develop and implement a monitoring process in the home to ensure that the policies and protocols related to obtaining, documenting and communicating medication orders are being consistently complied with by the interdisciplinary team. The details of the process, including the people involved in monitoring and the actions taken with the results, must be documented.

Grounds / Motifs :

1. The licensee has failed to ensure the written policies and protocols, that were developed for the medication management system to ensure the accurate administration of drugs used in the home, were implemented for three residents in accordance with prevailing practices.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) regarding a medication error specific to palliative care

medications. The management in the home and pharmacy investigated this medication error and identified that there were concerns with the communication, administration and dispensing of the order in accordance with required policies. There was risk of harm to residents in the home related to medication ordering practices not having been implemented in accordance with the home's policies and prevailing College of Nurses of Ontario (CNO) practices.

The "Palliative Care Orders" for three residents did not include all of the required information in accordance with the home's policy and prevailing practices. The indication for use was not included in the orders for two out of the three residents. The route of administration was not included in the orders for one out of the three residents. The name of the prescriber was not included in the orders for two out of the three residents. Documentation that it was a telephone order was not included for two out of the three residents. The three residents' electronic Medication Administration Record (eMAR) also showed prior to the palliative care orders having been implemented, multiple other medication orders did not include the indication for use.

The staff, management and pharmacist reported that due to the COVID-19 pandemic the primary mode for obtaining medication orders from physicians in the home over the past several months had been telephone orders. The home had identified concerns with the processes for obtaining and processing telephone orders and were working on improvements to reduce the risks. Based on the medication orders policy and the staff requirement to follow the best practices from the CNO, medication orders were required to include specific information and this was not a consistent practice implemented in the home.

Sources: a Critical Incident System (CIS) report; a Medication Incident Report; the home's "Medication Orders New Orders Policy" dated August 15, 2018; clinical records for the three residents including Prescriber Orders Sheets; interview with a Registered Nurse (RN) and other staff. [s. 114. (3) (a)]

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

Severity: There was actual risk of harm because the home's written policies and protocols for medication orders were not fully implemented in accordance with prevailing practices for a resident's end of life care medication orders.

Scope: This non-compliance was widespread the written policies and protocols for medication orders were not fully implemented for three out of three residents.

Compliance History: Ten written notifications (WN), 22 voluntary plans of correction (VPCs) and 10 compliance orders (COs) were issued to the home related to different sections of the legislation in the past 36 months. (630)

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 17th day of November, 2020

Signature of Inspector /
Signature de l'inspecteur :

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

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