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

London Service Area Office
130 Dufferin Avenue 4th floor
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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
Sep 13, 2021	2021_607523_0023	010219-21, 010325-21, 011028-21, 011976-21, 012487-21	Complaint

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

ALI NASSER (523), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

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

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 24, 25, 26, 27, 30, 31, September 1, 2 and 3, 2021.

This inspection was completed concurrently with critical incident inspection #2021_607523_0022 and follow up inspection 2021_917213_0002.

This inspection was complete for complaints related to continence care and allegations of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), registered nurses, registered practical nurses, personal support workers and residents.

The inspector(s) also toured the home, observed residents and care provided to them, reviewed clinical records, incident reports, investigation notes and reviewed specific policies and procedures of the home.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **2 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. (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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee has failed to ensure that the wound care set out in the plans of care for specific residents was provided to the residents as specified in the plans.

An anonymous complaint was received by the Ministry of Long-Term Care regarding wound care orders not being processed or implemented on time.

Wound treatment orders written on specific dates for specific residents were not initiated in the Treatment Administration Record and treatment was not provided until six days after they were ordered.

The ADOC said that the wound orders for specific residents were not processed on time as per policy and then the treatments were not provided as ordered.

Sources: Health records for specific residents and interview with ADOC. [s. 6. (7)]

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

A complaint was received by the Ministry of Long-Term Care regarding specific resident's care that was not provided to the resident as specified in their plan of care.

A clinical record review for the resident showed that the resident was found unresponsive. No CPR was noted to be initiated.

A clinical record review showed the resident was “Full Code-attempt CPR”

In an interview a specific RN said that the resident was full Code and the staff should have provided the care and started CPR.

In an interview ADOC said that CPR was not provided for the resident even though resident was full code. The care for the resident was not provided as it was set out for in the plan of care.

Sources: Resident's health care records and staff interviews. [s. 6. (7)]

3. The licensee has failed to ensure that a specific resident was reassessed, and the plan of care reviewed and revised when the resident’s care needs were changed.

A complaint was received by the Ministry of Long-Term Care regarding a specific resident who had a change in condition. The physician was not notified of this change in condition.

A clinical record review showed the resident had a change in condition over a period of five days. The physician was not aware of this change and the resident was not reassessed.

In an interview ADOC said resident had a decline and change in condition, the physician was not informed and the resident was not reassessed by the physician.

Sources: Resident's health care records and staff interviews. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system were complied with.

Ontario Reg. 79/10, s. 114 (2) stated “The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.”

The Ministry of Long-Term Care received a complaint on a specific date. The complainant stated they have found physician orders that were not transcribed as per policy, nurse checks were not signed within 24 hours and when signed they were not dated.

A review of the home’s policy , subject Physician’s Orders, Tab-05-08, procedure showed that the nurse will date and initial the order has been processed,
In an interview Acting DOC #101 said that the expectation was for the nurse transcribing the order to complete the 1st check, the nurse will sign and date. The nurse on the incoming shift will complete the 2nd check to ensure everything was completed correctly and the 2nd nurse will sign and date the 2nd check.

A review of a sample of the orders for multiple residents showed missing first and second nurse checks, and checks that were signed and not dated.

ADOC said they were aware of those concerns, the home had recently implemented new changes to the medication system and staff were currently receiving training on the new process that will also ensure the checks are put in place accordingly and in timely manner.

Sources: Resident's health care records, home's specific policies and procedures and staff interviews. [s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Findings/Faits saillants :

The licensee has failed to ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member’s qualifications, previous employment and other relevant experience.
2. Where applicable, a verification of the staff member’s current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member’s current registration with the regulatory body governing his or her profession.
3. Where applicable, the results of the staff member’s police record check under subsection 75 (2) of the Act.
4. Where applicable, the staff member’s declarations under subsection 215 (4).

In an interview a complainant informed inspector that agency staff did not receive any mandatory training in the home and were not aware of some of the processes.

In an interview Agency Registered Practical Nurse said they did not receive any mandatory training when they started at the home.

In an interview ADOC said that staff would receive mandatory training with their agency before they start at the home. ADOC said they had no record of training provided for the agency staff and they had no staff records for the agency staff in the home.

Sources: Staff interviews. [s. 234.]

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 a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.
3. Where applicable, the results of the staff member's police record check under subsection 75 (2) of the Act.
4. Where applicable, the staff member's declarations under subsection 215 (4)., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a specific resident who was exhibiting altered skin integrity in two areas, was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

A clinical record review showed the specific resident had two altered skin integrity in two areas that were not assessed weekly on specific dates.

The ADOC said that two wounds for the specific resident were not assessed as required on specific dates.

Sources: Health records for specific resident and interview with ADOC. [s. 50. (2) (b) (iv)]

Issued on this 14th day of September, 2021

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) :	ALI NASSER (523), RHONDA KUKOLY (213)
Inspection No. / No de l’inspection :	2021_607523_0023
Log No. / No de registre :	010219-21, 010325-21, 011028-21, 011976-21, 012487-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 13, 2021
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

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

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

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 :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must comply with s. 6 (7) of the LTCHA.
Specifically, the licensee must:
1. Review and revise if necessary, the home's policies, procedure and/or forms related to CPR and Advanced Care Planning / Expressing Wishes. This review must be interdisciplinary, including a minimum of the Administrator, the Medical Director and the Director of Care.
2. Provide training to all relevant staff, including but not limited to, all registered nursing staff and physicians. A record of such training must be kept to include the training provided and date completed, to ensure that all applicable staff have completed the training.
3. Ensure current and future residents / SDMs are aware of the CPR policy before completing the POET Individualised Summary SV1 form.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care for a specific resident was provided to the resident as specified in the plan.

A complaint was received by the Ministry of Long-Term Care regarding specific resident's care that was not provided to the resident as specified in their plan of care.

A clinical record review for the resident showed that the resident was found unresponsive. No CPR was noted to be initiated.

A clinical record review showed the resident was "Full Code-attempt CPR"

In an interview a specific RN said that the resident was full Code and the staff should have provided the care and started CPR.

In an interview ADOC said that CPR was not provided for the resident even though resident was full code. The care for the resident was not provided as it was set out for in the plan of care.

Sources: Resident's health care records and staff interviews.

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

Severity: There was an actual risk related to CPR not being initiated to a full code resident.

Scope: was limited to this resident.

Compliance history: The home has a history of non-compliance related to this subsection of the legislation.

(523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2021

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

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

Order # / No d'ordre : 002

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must comply with s. 6 (10) of the LTCHA.

Specifically, the licensee must ensure that the physician is informed when a resident has a change in condition so the resident can be reassessed and their plan of care reviewed and revised in order for resident to receive treatment as needed.

Grounds / Motifs :

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

1. The licensee has failed to ensure that a specific resident was reassessed, and the plan of care reviewed and revised when the resident’s care needs were changed.

A complaint was received by the Ministry of Long-Term Care regarding a specific resident who had a change in condition. The physician was not notified of this change in condition.

A clinical record review showed the resident had a change in condition over a period of five days. The physician was not aware of this change and the resident was not reassessed.

In an interview ADOC said resident had a decline and change in condition, the physician was not informed and the resident was not reassessed by the physician.

Sources: Resident's health care records and staff interviews

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

Severity: There was an actual risk related to the physician not being informed of the resident’s change in condition, the resident was not reassessed, and plan of care was not updated when the resident’s care needs were changed.

Scope: was limited to this resident.

Compliance history: The home has a history of non-compliance related to this subsection of the legislation.
(523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2021

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 13th day of September, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ali Nasser

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