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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 30, 2021	2021_788721_0019	015901-21, 016753-21	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

MEAGAN MCGREGOR (721), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 2-5, 8-10, 15 and 16, 2021.

The following complaint intakes were inspected during this inspection:

Log #015901-21 related to concerns about staff to resident abuse; and
Log #016753-21 related to concerns about medication administration.

During the course of the inspection, the inspector(s) spoke with the General Manager, the Assistant General Manager, the Director of Care (DOC), two Assistant Directors of Care (ADOCs), a Neighbourhood Coordinator, a Resident Assessment Instrument (RAI) Coordinator, an Exercise Therapist (ET), the Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a PSW Student, housekeeping staff, screeners and residents.

The Inspectors also toured the home and observed IPAC practices in place and the care being provided to residents; reviewed clinical records and plans of care for the identified residents; and reviewed the home's documentation related to the concerns identified.

This inspection was conducted concurrently with Critical Incident System (CIS) Inspection #2021_788721_0018. An Infection Prevention and Control (IPAC) observational checklist was completed as part of this inspection.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

- **3 WN(s)**
- **3 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. 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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care related to the administration of a specific medication to a resident that set out clear directions to the registered nursing staff.

The Ministry of Long-Term Care (MLTC) received a complaint related to concerns that a resident was not receiving a specific medication as ordered. On multiple occasions it was observed the resident was not provided the medication at the time it was ordered and on one date they were administered the medication twice.

The Medication Administration Audit Report for this date documented a specific administration time by an RN for an order which reminded staff about the administration time and location for this medication. The scheduled administration time for this order was approximately one hour after the time that it was documented as administered on this date.

The RN that documented the administration of the order on this date stated the direction

was unclear, this order was an alert for registered staff on the following shift to administer the medication at a specific time, however the alert automatically signaled the registered staff on the shift they were working an hour prior to the scheduled administration time and that was why they administered the medication at that time. The RN also said the direction was unclear because it stated to administer the medication in a specific location and they thought it meant the medication was kept in this location. The RN shared that the word “administer” being used in an alert was misleading and the alert should have been scheduled on the following shift for the registered staff responsible for administering the medication. The order for the medication was scheduled to be administered two and a half hours after the alert for the reminder to administer the medication notified staff, which was on a different shift.

The RAI Coordinator and the Assistant General Manager verified the alert was unclear and should have been scheduled at the same time the order for the medication was scheduled to be administered for the auto generated reminder to alert the registered staff on the shift responsible for administering the medication one hour before the medication administration time.

Sources: MTLC Complaint Infoline, Medication Administration Audit Report, the resident’s clinical record, and interviews with the complainant, RN, RAI Coordinator, Assistant General Manager and the resident. [s. 6. (1) (c)]

2. The licensee shall ensure that the staff and others involved in the fall prevention care of a resident collaborated with each other in the implementation of fall prevention interventions.

The current care plan in PointClickCare (PCC) for the resident documented a risk for falls and a specific intervention related to fall prevention. The intervention was created by the ET and further revised on two separate occasions in the month that followed.

A progress note documented that this specific intervention was to be implemented but this intervention was not added to the plan of care until approximately three months later. In the four-month period after it was first documented that this specific intervention was to be implemented, the resident sustained seven falls and was at increased risk of injury. Although the plan of care for the resident was revised on two occasions by the ET, the resident was not observed as part of that assessment. The ET was to ensure that the fall prevention intervention was in place to reduce the risk of injury from falls and if they had of observed the resident as part of this assessment they would have noted that the

intervention was not in place. They ET shared that the resident had frequent falls and they were responsible for updating the care plan related to falls prevention. The General Manager shared that the ET should have followed up to ensure that the intervention was still in place.

A PSW and ADOC verified the fall prevention intervention was not in place for the resident at the time of the inspection. The PSW stated they had never implemented this intervention for this resident, there was no task related to the intervention for them to document in Point of Care and the supplies required to implement the intervention for the resident were not available to them. An RPN stated this intervention had been implemented for the resident and that it was care planned, but there was no assigned task for staff to document on the intervention.

Sources: MLTC Complaint Infoline, the residents clinical record, interview with the ADOC, General Manager, RPN, ET, PSW and the resident, and observations. [s. 6. (4) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: 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 failed to ensure that a medication was administered to a resident in accordance with the directions for use as specified by the prescriber.

The MLTC received a complaint related to concerns that a resident was not receiving a specific medication as ordered. On multiple occasions it was observed the resident was not provided the medication at the time it was ordered and on one date they were administered the medication twice.

The Medication Administration Audit Report for this date documented an administration time of approximately one hour before it was scheduled by an RN for an order which reminded staff about the administration time and location for this medication. This order was only an alert to remind staff about another order that was scheduled for administration one and a half hours later that directed staff to administer the medication. The order that directed staff to administer the medication was documented as administered by another RN on this date approximately one hour after the order was scheduled.

Both RN’s verified that they administered a dose of this medication to the resident on this date, one dose which was administered approximately two and a half hours before the order that directed staff to administer the medication was scheduled and a second dose which was administered approximately one hour after the order that directed staff to administer the medication was scheduled.

The RAI Coordinator and Assistant General Manager verified the medication was administered twice and should have only been given once.

The resident was at risk for an adverse drug reaction as a result of having received twice the prescribed dosage of this medication.

Sources: MLTC Complaint Infoline, Medication Administration Audit Report, the resident’s clinical record, and interviews with the complainant, RNs, RAI Coordinator, Assistant General Manager, and the resident. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the IPAC program related to hand hygiene practices and the use of personal protective equipment (PPE) when caring for residents under droplet contact precautions.

On November 8, 2021, a resident was sitting in their room and there was a PPE cart available and a droplet contact precautions sign posted by their door. On this same date it was reported to Inspector #563 that staff were entering and exiting the resident's room without donning the appropriate PPE which included a gown, mask and eye protection.

Video evidence was obtained by the management team in the home showing individual staff members who were not following the home's droplet contact precaution protocol for the use of PPE.

Four residents were placed on droplet contact precautions between November 5, 2021, and November 8, 2021, related to COVID-19 exposure and respiratory symptoms. These residents resided on the same neighbourhood in which a precautionary outbreak was declared for respiratory symptoms starting November 8, 2021.

On November 8, 2021, the following was observed on this neighbourhood:

- A PSW Student was transporting a resident by wheelchair to the dining room wearing disposable gloves that were discarded at the entrance to the dining room and they did not perform hand hygiene before collecting cups and glasses from resident tables. The PSW Student also dropped a plastic cup in the garbage, retrieved it and then continued to collect used glasses and soup dishes from resident tables and assist other residents without performing hand hygiene between clean and dirty tasks. The PSW Student stated they provided personal care to the resident before transporting them to the dining room and had changed their gloves before taking the resident to the dining room. They could not explain why they were wearing gloves while transporting the resident by wheelchair and could not explain the moments of hand hygiene.
- Two PSW Students cleared dishes from different tables and returned to assist residents with feeding and other dining care without performing hand hygiene between these tasks.

- Tray service was brought to a resident identified to be on droplet contact precautions in their room by a PSW who donned a gown only when entering the room, with no eye protection in use and did not change their mask when exiting the room. The PSW verified they delivered the residents meal tray to the room and stated they forgot to don eye protection and did not change their mask when exiting the room and doffing PPE.
- A Housekeeper was not wearing eye protection while cleaning the room of a resident identified to be on droplet contact precautions, however they appropriately doffed the PPE that was being worn when exiting the room and donned the appropriate PPE before then entering the room of another resident on droplet contact precautions. The Housekeeper stated they had not donned eye protection before entering the first residents room as there were no goggles available in the PPE cart outside their room and that the PPE carts were set up by the nurses the way they were intended to be used. They verified that the droplet contact precaution signage on this residents door clearly indicated the use of gown, gloves, and eye/mask protection.

An ADOC stated education was being delivered to all staff on all shifts to review donning and doffing of PPE and isolation measures. Management staff were on each neighbourhood in the home delivering the education. The DOC stated the PSW Student Instructor was onsite related to other identified concerns with a PSW Student who did not want to don PPE in a room with a resident on droplet contact precautions and who had taken a resident out of their room to the dining room when they were supposed to be in isolation.

The Assistant General Manager and General Manager said they obtained video evidence of the charge nurse and PSW staff entering a residents room who was identified to be on

droplet contact precautions on November 7, 2021, without donning appropriate PPE and one PSW was not wearing a mask. The General Manager explained that before entering a residents room staff were required to take off their current mask and put on a new mask, gloves, gown and goggles/shield, and then doff it all coming out of the room, including changing their mask for all residents on droplet contact precautions.

On November 9, 2021, the General Manager stated they had received additional video evidence showing a PSW entering the room of a resident who was identified to be on droplet contact precautions without donning the appropriate PPE. They said the PSW had received education the previous day on evening shift from an ADOC and then the PSW went into that resident’s room after dinner only wearing a mask.

On November 10, 2021, the General Manager shared that one of the residents previously identified to be on droplet contact precautions related to COVID-19 exposure had been confirmed positive for COVID-19. On this same date a COVID-19 outbreak was declared by public health on this neighbourhood.

On November 15, 2021, signage was observed on the entrance to the neighbourhood indicating an active COVID-19 outbreak was declared on this neighbourhood and droplet contact precautions were in place. A staff member was observed sitting at the nursing station without eye protection at this time.

Poor staff compliance with implementation of routine hand hygiene and PPE donning and doffing protocols on one of the neighbourhoods in the home identified to be in outbreak increased the risk of exposure and transmissibility of an acute respiratory infection between residents and staff in the home.

Sources: Resident clinical records, observations, and interviews with PSW Students, PSWs, nurse leadership staff, a family member and residents. [s. 229. (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 all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 1st day of December, 2021

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

Original report signed by the inspector.