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
Mar 10, 2022	2022_979740_0008	014618-21, 014619-21, 017564-21, 019116-21, 019217-21, 019351-21, 019496-21, 020393-21, 020639-21, 021027-21, 001226-22, 001278-22	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

SAMANTHA PERRY (740), ALI NASSER (523), CHERYL MCFADDEN (745)

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): February 22, 23, 24, 25, 28, March 01, 02 and 03, 2022.

The following Critical Incident Systems (CIS) and Follow-Up intakes were completed within this (CIS) inspection:
Log# 017564-21 / CI# 2979-000064-21 related to fall management;
Log# 019116-21 / CI# 2979-000068-21 related to fall management;
Log# 019217-21 / CI# 2979-000069-21 related to medication administration;
Log# 019496-21 / CI# 2979-000071-21 related to responsive behaviours;
Log# 020393-21 / CI# 2979-000075-21 related to medication administration;
Log# 020639-21 / CI# 2979-000079-21 related to resident care concerns;
Log# 021027-21 / CI# 2979-000082-21 related to fall management;
Log# 001226-22 / CI# 2979-000002-22 related to responsive behaviours;
Log# 001278-22 / CI# 2979-000003-22 related to fall management;
Log# 014618-21 for Compliance Order (CO) #001 from inspection #2021_607523_0023 related to plan of care;
Log# 014619-21 for Compliance Order (CO) #002 from inspection #2021_607523_0023 related to plan of care and;
Log# 019351-21 for Compliance Order (CO) #001 from inspection #2021_788721_0018 related to abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Administrator, the Director of Care, the Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeepers and residents.

The inspector(s) also made various observations, including Infection Prevention and Control practices, and reviewed residents' clinical records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Responsive Behaviours

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

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2021_788721_0018	523
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2021_607523_0023	523
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2021_607523_0023	523

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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

The home submitted two Critical Incident System (CIS) to the Ministry of Long Term Care (MLTC), related to medication incidents involving two different residents receiving medications that were not prescribed for them.

Clinical record reviews for resident #010 and resident #011 documented, two different medication incidents where the residents received several medications not prescribed for them.

RPN #114, RN #118, and Administrator #108, said residents #010 and #011 were administered drugs that were not prescribed for them.

As a result, there was an increased risk to residents #010 and #011 when they were administered medications not prescribed for them.

Sources: Clinical Record reviews and staff interviews. [s. 131. (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 by ensuring that no drug is administered to a resident in the home unless the drug is prescribed for the resident, to be implemented voluntarily.

Issued on this 18th day of March, 2022

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

Original report signed by the inspector.