Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: January 11, 2023

Inspection Number: 2022-1461-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Glendale Crossing, London

Lead Inspector	**Inspector Digital Signature**
Samantha Perry (740)	Samantha Perry Digitally signed by Samantha Perry Date: 2023.01.12 10:06:30 -05'00'

Additional Inspector(s)
Rhonda Kukoly (213)
Peter Hannaberg (721821)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 12, 13, 14, 15, 16, 20, 21, 22, 28, 29, 30, January 3, 4, 5, and 9, 2023.

The following intake(s) were inspected:

- Intake: #00001472- CI: 2979-000044-22, Intake: #00001521- CI: 2979-000056-22, Intake: #00002230- CI: 2979-000070-22, Intake: #00003945- CI: 2979-000077-22, Intake: #00004790- CI: 2979-000035-22, Intake: #00004791- CI: 2979-000038-22, Intake: #00005383- CI: 2979-000068-22, Intake: #00007373- CI: 2979-000084-22, Intake: #00008470- CI: 2979-000091-22, Intake: #00012417- CI: 2979-000105-22, Intake: #00013621- CI: 2979-000108-22, Intake: #00013625- CI: 2979-000107-22, Intake: #00014126- CI: 2979-000110-22, related to falls management;
- Intake: #00001746- CI: 2979-000047-22, Intake: #00015079- CI: 2979-000117-22, related to responsive behaviours management;
- Intake: #00002136- CI: 2979-000088-22, related to a resident's unexpected death;
- Intake: #00005939 and Intake: #00014717 were complaints related to responsive behaviours management;
- Intake: #00007821- CI: 2979-000043-22, related to medication incidents;

- Intake: #00011748- Complaint related to pain management;
- Intake: #00001834- CI: 2979-000059-22 related to an injury of unknown origin and;
- Intake: #00004770- CI: 2979-000086-22 related to responsive behaviours.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Responsive Behaviours
Infection Prevention and Control
Palliative Care
Falls Prevention and Management
Prevention of Abuse and Neglect
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Behaviours and Altercations

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 60 (a).

The licensee has failed to comply with Schlegel Villages' Personal Expressions Program policy related to determining the risk to residents and the completion of a Personal Expressions Resource Team (PERT) resident assessment following an incident.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protocols were developed for the responsive behaviours program, also known as the personal expressions program, and to ensure these policies and protocols were complied with.

Specifically, staff did not comply with the Personal Expressions Program policy (number 04-84, last reviewed May 1, 2022).

Rationale and Summary
An incident resulting in injury occurred between two residents, and at the time of the incident,

responsive behaviours had been identified for each resident. As per the home's policy, the staff were required to determine the level of risk to each resident involved in the incident, which would then be documented within a PERT assessment in Point Click Care (PCC).

A review of the clinical records for the residents involved was completed with Director of Care (DOC) #108, and it was determined that PERT assessments had not been completed in response to this incident. DOC #108 confirmed that a risk level had not been determined, a referral to PERT had not been initiated, and that a PERT assessment had not been completed in PCC in response to the critical incident. DOC #108 stated these tasks should have been performed by the staff responding to the incident as per the home's policy.

Sources: review of resident clinical records, Personal Expressions Program policy; interviews with staff. [721821]

WRITTEN NOTIFICATION: Pain management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 57 (1) 4.

The licensee has failed to ensure a resident’s response to their pain management strategies were monitored for effectiveness.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint related to a resident’s pain management.

Review of the resident’s clinical records documented the resident experienced pain and was administered pain medication. However, the staff did not monitor or document the resident’s response to, and effectiveness of, their pain management strategies after the pain medication was administered. According to the legislation, the home’s pain management program policy and interviews with staff, it was the expectation that the resident’s response to, and the effectiveness of the administered pain medication should have been monitored and documented.

Sources: Resident clinical records, the home’s pain management program policy and interviews with staff and management. [740]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 58 (4) (c).

The licensee has failed to ensure that when a resident was demonstrating responsive behaviours, actions such as, assessments, reassessments and interventions were taken to respond to the resident's needs.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint related to a resident's unmanaged responsive behaviours.

A review of a resident's clinical records documented the resident expressed responsive behaviours. Multiple staff members were aware of the resident's expressed behaviours; however, there were no actions taken such as, an assessment or reassessment by staff to respond to the resident's needs. According to the legislation, the home's personal expressions program policy and interviews with staff, the expectation would have been to assess and reassess the resident after each expressed responsive behaviour to ensure the resident was not injured or required further interventions. There was risk the resident's needs would go unmet without an assessment of the resident when they were expressing responsive behaviours.

Sources: Resident clinical records, the home's responsive behaviours policy and interviews with staff and management. [740]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (iii).

The licensee has failed to ensure that a resident's injury of unknown origin was immediately investigated.

O. Reg 246/22 s. 115 (3) states: The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5): An incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Rationale and Summary
The home reported in a critical incident, that an injury of unknown origin was identified for a resident and the resident was complaining of severe pain. A staff member said they had expected the home

would do an investigation and someone would ask them about what happened, but no one did. The Director of Care said they assumed there was no foul play and therefore, an investigation was not completed. There was risk that the injury was caused by something that was not investigated, not identified, and not acted on.

Sources: Critical Incident Report #2979-000059-22, resident clinical records and staff interviews. [213]

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c).

The licensee has failed to ensure that the written plan of care related to medication administration set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
The home reported a critical incident report related to a medication incident.

A review of a resident's clinical records documented the resident had an order for a medication to be administered in a certain amount. However, there were other clinical records that documented the resident received a different amount of the medication.

The Long-Term Care Home (LTCH) staff said the direction for this medication was not clear and should have been. There was risk that the resident may not have received the appropriate amount of a medication due to unclear direction.

Sources: A critical incident report, resident clinical records, and staff interviews. [213]

WRITTEN NOTIFICATION: Documentation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in the plan of care, related to a medication, was documented.

Rationale and Summary
The home reported a critical incident report related to a medication incident.

A review of a resident's clinical records documented the resident had an order for a medication to be administered in a certain amount. However, staff did not document every time they administered the medication.

The Long-Term Care Home (LTCH) staff said when a medication is administered, documentation of the administration is required. There was risk that the resident may not have appropriate follow up without review of the medication administration records.

Sources: A critical incident report, resident clinical records, the Long Term Care Home's policy, and staff interviews. [213]

WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
The home reported a critical incident report related to a medication incident.

A new medication order was received for a resident, for which the home did not have a ready supply. The order was processed incorrectly and the incorrect amount was administered to the resident on two separate occasions before the error was identified.

Sources: A critical incident report, resident clinical records, medication incident form, and staff interviews. [213]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 147 (1) (a).

The licensee has failed to ensure that a medication incident was documented together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary
The home reported a critical incident report related to a medication incident.

There was no documentation of an assessment of the resident following the discovery of the medication administration error in the medication incident report or in the resident's health records. The Director of Care said the expectation would be for the resident to be assessed, including vital signs, and the assessment to be documented after the medication incident was discovered.

The home's pharmacy provider policy Reporting Medication Incidents stated: Upon discovery of a medication incident, the health and safety of the resident is the first priority. The resident's condition is assessed, and immediate action is taken if needed. There was risk to the resident that an adverse reaction was not discovered or appropriately treated when the resident was not assessed, and the assessment was not documented.

Sources: A critical incident report, pharmacy policy Reporting Medication Incidents #7.3 with a revision date of April 2022, resident clinical records, a medication incident form, and staff interviews. [213]

WRITTEN NOTIFICATION: Skin and wound care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (a) (ii).

The licensee has failed to ensure that a resident who was at risk of altered skin integrity, received a skin assessment by a member of the registered nursing staff, within 24 hours of their return to the home.

Rationale and Summary
The home reported a critical incident report related to a medication incident.

When the resident returned to the Long Term Care Home they were supposed to have a skin assessment, as they had been away from the home for greater than 24 hours. A Registered Nurse and the Director of Care said that a head-to-toe assessment must be completed within 24 hours of returning to the home and this was not done.

The Schlegel Villages Return to the Village policy stated: Complete the computerized Return to Village Assessments, including Skin Assessment. There was risk that the resident had unidentified altered skin integrity when they were not assessed within 24 hours of their return to the home.

Sources: A critical incident report, resident clinical records, the Schlegel Villages Return to the Village policy, and staff interviews. [213]