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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: February 29, 2024	
Inspection Number: 2024-1461-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Glendale Crossing, London	
Lead Inspector Peter Hannaberg (721821)	**Inspector Digital Signature** Peter Benjamin Hannaberg Digitally signed by Peter Benjamin Hannaberg Date: 2024.03.04 09:34:49 -05'00'
Additional Inspector(s) Henry Otoo (000753)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6-8, and 12-16, 2024.

The following intake(s) were inspected:

- Intake #00107639 - Proactive Compliance Inspection - 2024.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils

Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 148 (2) 1.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

The licensee has failed to ensure that non-controlled drugs that were to be destroyed and disposed of, were stored safely and securely within the home until the destruction and disposal occurred.

The licensee was required to ensure that their drug destruction and disposal policy provided that drugs to be destroyed and disposed of were stored safely and

securely within the home, separate from drugs that were available for administration to a resident, until the destruction and disposal occurred, and this policy must be complied with.

Staff did not comply with the home's policy which stated, medications being stored prior to destruction would be stored in a medication waste container, in the medication room, separate from any active medications available for administration to a resident, until the drug destruction and disposal occurred.

Rationale and Summary
During the inspection medications designated for destruction were observed to be stacked on top of the medication waste container in one of the medication rooms. Inspector #721821 noted that the medication waste container was completely filled, and these medications were sitting on top of the lid since they could not fit into the waste container.

Interviews with the Director of Care (DOC) and Assistant Director of Care (ADOC) confirmed that these medications were being stored improperly while awaiting destruction and disposal.

A follow-up observation of the medication room was completed by Inspector #721821 on a later date, and there were no medications being stored on top of the medication waste containers. The waste containers were being stored securely inside the locked medication room, only accessible by the nursing staff.

Sources: observations, interviews with staff, and review of the home's medication destruction policy.
[721821]

Date Remedy Implemented: February 8, 2024

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 184 (3)

Directives by Minister

s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure that every Minister's Directive that applies to the long-term care home was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, the licensee was required to ensure that the masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, were followed.

Rationale and Summary

During the inspection two staff members who were providing care for a resident did not wear their face masks.

By not wearing their masks, infectious agents causing disease could be transferred from the staff members to the resident.

Sources: Observation, and interview.

[000753]

WRITTEN NOTIFICATION: Infection prevention and control program

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

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control.

The licensee has failed to ensure that staff members implemented the infection prevention and control (IPAC) program including any standard issued by the Director.

Two staff members failed to ensure that additional precautions were followed in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the staff did not select or apply the proper Personal Protective Equipment (PPE) as was required by Additional Requirement 9.1 (f) under the IPAC Standard.

Rationale and Summary
During the inspection, two staff members were observed outside of a resident's room. Signage was posted which required staff performing care to wear specific PPE. The PSWs did not all of the specified PPE while providing care for the resident.

When interviewed, both staff confirmed that they should have donned all the required PPE, and that they did not wear the required PPE as identified on the signage.

Sources: observation, and staff interviews.
[721821]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee failed to ensure that the continuous quality improvement committee included at least one employee who was a member of the regular nursing staff of the home.

Rationale and Summary
A record review of the homes last two Continuous Quality Improvement (CQI) Meeting Minutes indicated that a regular registered nursing staff member position was vacant.

The CQI Lead during interview said, the home lost the registered staff member who was on the CQI committee and have not been able to replace them for many months. The last two PAC meetings were without a regular registered staff member.

By not including a regular nursing staff member the home was missing the input of a frontline staff member who regularly supported residents and had firsthand experiences about quality improvement challenges and may have contributed to ideas for improvements.

Sources: Record reviews and staff interviews.
[000753]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee failed to ensure that a copy of the continuous quality improvement initiative report was provided to the Residents' and Family Councils.

Rationale and Summary
During inspection, the CQI Initiative report was not found in the Family and Resident Council binders available in the home's Public Library during review. There was no copy of the CQI Initiative Report available on the Resident and Family Council Board in the main hallway of the home as well.

The home's CQI Lead said during interview that a copy of the CQI report was not provided to the Residents' and Family Councils.

By not sharing the CQI Initiative report with the Resident and Family Councils, there was a potential impact of missed contributions from families and residents, and how the home was held accountable by residents and families because of lack of information shared.

Sources: Record Reviews and staff interviews.
[000753]

WRITTEN NOTIFICATION: Orientation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (d)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(d) respiratory etiquette;

The licensee has failed to ensure that training for the staff in infection prevention and control (IPAC) included respiratory etiquette.

Rationale and Summary
The training and orientation education for IPAC was required to include a component on respiratory etiquette. After review of the training materials provided to staff at orientation and during orientation, respiratory etiquette was not included.

An interview with the IPAC Lead who delivered the IPAC orientation training confirmed that respiratory etiquette was not included in the education materials.

Sources: review of the IPAC training materials, and in interview with the IPAC Lead. [721821]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.

The licensee failed to ensure that Falls Prevention and Management training was provided to all staff who provided direct care to residents.

Rationale and Summary
The DOC provided copies of the online training record of a registered staff member. The records indicated that the staff member in did complete some training on lifts and transfers, but there was no record of training for Falls Prevention and Management.

The DOC said during an interview that the registered staff member missed their training for Falls Prevention and Management because the home's head office did not add it to the staff's online training.

By not receiving the mandatory falls prevention and management training there was a gap in knowledge and potential quality of care provision to residents by the registered staff member who did not receive the required training.

Sources: Staff interview and record review.
[000753]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

2. Skin and wound care.

The licensee failed to ensure that Skin and Wound Care training was provided to all staff who provide direct care to residents.

Rationale and Summary
A record review of a registered staff's orientation training indicated that they were missing some components of the required skin and wound care training.

In an interview with the DOC, they said some registered staff members were missing some trainings related to the skin and wound care program. They said the corporate office was assigning training modules to all registered staff to complete to rectify the gap.

Not receiving the mandatory skin and wound care training potentially created a gap in knowledge and quality of care provision to residents by the registered staff members who did not receive the required training.

Sources: Record review and staff interviews.
[000753]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of

pain.

The licensee failed to ensure that Pain Management training was provided to all staff who provided direct care to residents.

Rationale and Summary
A record review of a registered staff member's orientation training indicated that they missed some of the required pain assessment education.

In an interview with the DOC, they said some staff members were missing part of their training related to the pain management program. The DOC said staff received pain management training for the retirement home and not Long-Term Care. They said the corporate office was assigning training modules to all registered staff to complete to rectify the gap.

Not receiving the mandatory pain prevention and management training potentially impacted the knowledge and quality of care provision to residents by the registered staff members who did not receive the required training.

Sources: Record reviews and staff interviews.
[000753]