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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 23, 2024
Original Report Issue Date: May 22, 2024
Inspection Number: 2024-1461-0002 (A1)
Inspection Type: Complaint Critical Incident Follow up
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Glendale Crossing, London

Amended By Henry Otoo (000753)	**Inspector who Amended Digital Signature** Henry N Otoo Digitally signed by Henry N Otoo Date: 2024.05.23 14:02:29 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Ensure the report reflects the

- Compliance Due Date of CO#001 of June 14, 2024
- To include PSW#126 in the details of the CO#001

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Lead Inspector Henry Otoo (000753)	**Additional Inspector(s)** Debbie Warpula (577)
Amended By Henry Otoo (000753)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
Ensure the report reflects the

- Compliance Due Date of CO#001 of June 14, 2024
- To include PSW#126 in the details of the CO#001

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, 2024 and May 1, 2, 3, 6, 2024

The following intake(s) were inspected:

- Intake #00106614 was a Follow-up regarding CO#001 / #2023-1461-0007 related to Medication Management System
- Intake #00108856 was related to concerns regarding staff not following plan of care for a resident
- Intake #00109135 was related to concerns with catheter care, short staffing in the home and menu planning
- Intake #00111016 / Critical Incident System# 2979-000013-24 was related to Fall of a resident
- Intake #00112639 was related to concerns regarding care a resident
- Intake #00112644 was related to Fall of a resident
- Intake #00113183 was related to concerns of alleged physical abuse of a resident
- Intake #00113204 was related to concerns of possible retaliation
- Intake #00113337/Critical Incident System# 2979-000019-24 was related to care provision concerns of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1461-0007 related to O. Reg. 246/22, s. 123 (3) (a) inspected by Henry Otoo (000753)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

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,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's plan of care provided clear direction regarding mobility and transferring.

Rationale and Summary:

The Director received a concern of alleged improper care of a resident.

Review of the home's policy "Care Plans and MDS-RAI Coding" indicated that registered staff were responsible to update care plans when changes occurred.

During a review of the resident's care plan, the Inspector noted that the mobility and transferring interventions of the resident was not clear.

In an interview with a Registered staff member, they stated that the care plan was unclear and should have been updated.

In an interview with the Unit Coordinator, they stated that the resident's care plan had provided unclear directions related to their mobility and transfers.

There was low risk to the resident as the resident received the care they required based on assessments.

Sources: resident health care records, home's policy "Care Plans and MDS-RAI Coding", and interviews with staff. [577]

WRITTEN NOTIFICATION: Medication Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure the written policies and protocols for the medication management system were implemented.

Rationale and Summary:
In accordance with O. Reg. 246/22, s. 123 (3) the licensee was required to ensure that that written policies and protocols are developed for the medication management system to ensure the accurate administration of all drugs used in the

home.

In accordance with O. Reg. 246/22, s. 6. For the purposes of the Act and this Regulation, "drug" means a substance or a preparation containing a substance referred to in clauses (a) through (d) of the definition of "drug" in subsection 1 (1) of the Drug and Pharmacies Regulation Act, including a substance that would be excluded from that definition by virtue of clauses (f) to (i) of that definition, but does not include a substance referred to in clause (e) of that definition.

In accordance with Drug and Pharmacies Regulation Act, "drug" means any substance or preparation containing any substance, (a) manufactured, sold or represented for use in, (i) the diagnosis, treatment, mitigation or prevention of a disease, disorder, abnormal physical or mental state or the symptoms thereof, in humans, animals or fowl, or (ii) restoring, correcting or modifying functions in humans, animals or fowl.

In accordance with O. Reg 246/22 s.11 (1) b, the licensee was required to comply with the medication management system. Specifically, staff did not comply with the home's "Respiratory" policy.

A complaint was received by the Director alleging that staff were not following a resident's care plan.

Review of the home's policy indicated that an order from a physician was required for that medication. Review of the CareRx policy "The Medication Pass – 5.6" indicated that to administer drugs to residents, all Personal Support Workers (PSWs) must receive training on drug administration, have the appropriate skills, knowledge

and experience to administer drugs.

During observations of the resident, the inspector noted the resident did not receive their medication. Personal Support Worker (PSW) stated that they had forgotten.

During another observation of the resident, they received wrong dose of the medication.

In an interview with the Director of Care (DOC), they stated that PSWs had not received training on the administration of the medication.

The staff did not comply with the policies related to the administration of the medication and posed a risk to the resident.

Sources: review of the home's policy, resident's health care records, observations, and staff interviews. [577]

COMPLIANCE ORDER CO #001 Infection Prevention and Control program

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A) Ensure all isolation Personal Protective Equipment (PPE) carts are supplied with all required PPE, including gowns, gloves, eye protection, and masks, where additional precautions are in place.

B) Re-train six staff members on PPE requirements for residents on additional precautions. Maintain a record of the training provided including, dates, times, attendees, trainers and materials taught.

C) IPAC Lead or designate will conduct weekly audits to ensure PPE carts contain appropriate PPE for those residents on additional precautions and weekly audits of staff donning/doffing PPE for those residents on additional precautions. A documented record must be maintained of this audit, including the date the audit was completed, who completed the audit, the name of the resident the audit was completed for, any concerns identified, and the corrective action taken as a result of the audit. The auditing process must continue until the Compliance Order has been complied by an inspector.

Grounds

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

The licensee has failed to ensure all staff participated in the implementation of the Infection Prevention and Control Program (IPAC) in accordance with IPAC Standard for Long-Term Care Homes.

Specifically, the licensee has failed to ensure that Additional Precautions included the proper use of Personal Protective Equipment (PPE), including the appropriate selection, application, removal, and disposal as required by Additional Requirement

9.1 (f) under the IPAC Standard.

O. Reg. 246/22, s. 102 (2) (b) requires the licensee to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Summary and Rationale
A) Review of the home's policy "Personal Protective Equipment" indicated that the PPE recommendations for providing direct care to a suspect or confirmed Covid 19 resident case, staff were to wear a fit-tested, seal checked N95 respirator or equivalent, eye protection, gown, and gloves.

Review of the home's policy "Managing a Respiratory Outbreak" indicated that as part of managing a respiratory outbreak, residents who were symptomatic with an acute respiratory infection (ARI) would be place on Droplet/Contact Precautions and team members who entered into the resident's room would wear the applicable PPE.

On April 18, 2024, Inspector #577 observed three staff were not wearing eye protection and gown in a Covid outbreak area.

On April 19, 2024, the Inspector #577 observed two PSWs enter a resident's room not wearing eye protection and donning gloves from their uniform pocket. when the resident was on Contact/Droplet precautions for Covid.

In an interview with Registered Nurse and IPAC Lead, they advised that staff should have been wearing the appropriate PPE when providing care for residents on Contact/Droplet precautions. IPAC Lead also indicated that staff should not have donned gloves from their pockets, as the gloves would not be considered clean.

B) Review of the home's policy "Managing a Respiratory Outbreak" indicated that as part of managing a respiratory outbreak, the fire doors to the entrance of the neighborhood in outbreak would be closed. Appropriate outbreak signage would be posted at the entrance to the neighborhood, village entrance and within elevators.

During observations April 16, 17, 18, 19, 22 and 24, 2024, Inspector #577 noted the entrance fire doors to home area in outbreak had doors open and outbreak signage attached to the inside of the door.

In an interview with IPAC Lead, they stated that the doors should be closed but had been left open because that was the entry to the accessible elevator on that side.

C) Review of the home's policy "Transmission of Micro-organisms – Droplet Precautions" indicated that registered staff would set up an isolation station with required PPE and alcohol-based handrub at the entrance to the resident's room.

During observations on April 18, 2024, five rooms had not contained sufficient PPE supplies for Contact/Droplet precautions.

During observations on April 19, 2024, three rooms had not contained sufficient PPE supplies for Contact/Droplet precautions.

In an interview with IPAC Lead, they advised that it was the PSWs responsibility to replenish supplies on the PPE carts.

Email communication with Middlesex London Health Unit indicated that it was not Best Practice for staff to use gloves from their pockets as the gloves could become dirty; staff should be replenishing their PPE carts; and wearing appropriate PPE when providing direct care to or interacting with, a suspect or confirmed case of

COVID-19 and in the provision of direct care within two metres of residents in an outbreak area, as per the Middlesex-London Health Unit 'Covid-19 Outbreak Control Measures for Long-Term Care Homes'.

During an interview with the Director of Care (DOC), they indicated that all staff were required to be wearing appropriate PPE when providing care for a resident on Contact/Droplet precautions, PSWs were responsible to be replenishing PPE carts, and one fire door to the entrance of Westminster should have been closed during the Covid outbreak.

Staff not implementing the home's IPAC program by not wearing appropriate PPE, gowns, eye protection and gloves unavailable at point of care, and not closing the fire doors to the entrance of the neighborhood in outbreak put residents and staff at risk of potentially spreading healthcare associated infections, including COVID-19.

Sources: review of the home's "Personal Protective Equipment" policy, "Managing a Respiratory Outbreak" policy, "Transmission of Micro-organisms – Droplet Precautions" policy, Middlesex-London Health Unit "Covid-19 Outbreak Control Measures for Long-Term Care Homes", resident additional precaution list, observations and staff interviews.
[577]

This order must be complied with by June 14, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.