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: September 4, 2024
Inspection Number: 2024-1461-0003
Inspection Type: Complaint Critical Incident Follow up
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Glendale Crossing, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 23, 25, 29, 30, 31, 2024 and August 1, 2, 6, 7, 8, 12, 13, 14, 16, 2024

The inspection occurred offsite on the following date(s): July 26, 2024 and August 15, 2024

The following intake(s) were inspected:
Intake #00114888 related to complainant concerns regarding care concerns of a resident
Intake #00115403/ Critical Incident System (CIS) #2979-000024-24 related to allegations of abuse of a resident by a visitor
Intake #00115481 complaint intake related to concerns of potential retaliation from the home
Intake #00115942/ Critical Incident System (CIS) #2979-000026-24 related to alleged abuse of residents by staff
Intake #00116204/CIS# 2979-000027-24 related of allegation of Neglect of a resident by staff
Intake #00116842 related to Follow-up #: 1 - CO #001 from Inspection 2024-1461-

0002 regarding Infection Prevention and Control
Intake #00119001/CIS# 2979-000032-24 related to allegations of improper/Incompetent care of resident
Intake #00120602/ CIS#2979-000037-24 related to fall of a resident
Intake #00121255 / CIS# 2979-000042-24 related to allegations of abuse of a resident by a visitor
Intake #00122501/CIS# 2979-000045-24 related to a Missing Resident for less than 3 Hours
Intake #00122541 / CIS# 2979-000046-24 related to a Missing Resident for more than 3 Hours
Intake #00123259/ CIS# 2979-000050-24 related to Parainfluenza virus Outbreak

The following intakes were completed related to Falls Prevention and Management:
Intake #00117438/CIS# 2979-000031-24, intake #00116587/CIS# 2979-000028-24, and intake #00116657/CIS# 2979-000029-24.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1461-0002 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Henry Otoo

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control

Whistle-blowing Protection and Retaliation
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that they complied with their written policy to promote zero tolerance of abuse and neglect of residents, the Prevention of Abuse and Neglect policy.

Rationale and Summary
A staff member witnessed an incident between a resident and a visitor. The resident reported the incident to another staff member who did not report the abuse immediately before they went home at the end of their shift.

The first staff member did not intervene appropriately, and the second staff member failed to report the incident immediately.

Sources: Resident clinical records; Critical Incident System, SCHLEGEL VILLAGES Prevention of Abuse and Neglect Policy; resident and staff interviews.

WRITTEN NOTIFICATION: Policy to minimize restraining of residents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 33 (1) (b)
Policy to minimize restraining of residents, etc.
s. 33 (1) Every licensee of a long-term care home,
(b) shall ensure that the policy is complied with.

The licensee failed to ensure staff complied with the "Restraint and PASD (Personal Assistance Service Device) Procedures in LTC" policy related to a resident's equipment use.

Rationale and Summary

The home's policy required assessment of every resident before a restraint was considered and prior to the application of a restraint.

A resident's clinical records showed no assessment being completed before a restraint was considered or prior to the application of the equipment.

The Assistant Director of Care/Falls Lead verified that the assessment was not completed for a resident prior to use.

Sources: Resident's clinical record and staff interview.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from emotional abuse.

Rationale and Summary
A critical incident report was submitted by the home about an alleged emotional abuse.

The home's internal investigations concluded that a resident had been emotionally abused. The home had taken previous steps to minimize risk to the resident from abuse.

Sources: Resident clinical record; Critical Incident System; resident, and staff interviews.

WRITTEN NOTIFICATION: Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9)
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care.

The licensee failed to ensure that provisions, outcomes, and effectiveness of the care set out in the plan of care was documented for a resident.

Rationale and Summary
The resident had instructions in their plan of care related to monthly treatment which was not followed.

The resident's clinical records showed a registered staff nurse documented "refused" treatment but failed to communicate to oncoming staff that the resident refused their treatment for follow up.

The Director of Care confirmed it was the home's expectation to document when a resident refused care and need to communicate the refusal to oncoming staff.

Failure to properly communicate the treatment refusal to the oncoming staff, resulted in care needs not being met.

Sources: Resident's care plan, progress notes, home's policy, and interviews with staff.

WRITTEN NOTIFICATION: Doors in a home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 4.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

4. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

The licensee failed to ensure that locks on washrooms and toilets on the main floor were designed and maintained so they could be readily released from the outside in an emergency.

Rationale and Summary
During an interview with the Administrator, they said they were not sure the doors on the public washrooms where an incident had occurred could be opened from outside during that emergency.

The home changed the locks on the doors after the interview to allow opening from outside in an emergency.

Sources: Critical Incident System, observations, and staff interviews.

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the

assessment and that the plan is implemented.

The licensee failed to ensure a resident's individualized plan for promoting health and wellbeing was implemented.

Rationale and Summary
A resident who required treatment was documented that they "refused" treatment with no assessments why they refused and staff did not reapproach the resident again.

A registered staff nurse indicated the home's expectations was for the registered staff to document the date of the treatment, and refusal or attempted treatment. A nursing staff member did not complete the treatment nor indicated the resident's reason for refusal as per protocol.

The Director of Care said it was the home's expectation to document treatment as well as all refused or attempted treatments.

Failure to complete the resident's scheduled treatment, as per their individualized plan placed the resident at risk.

Sources: Resident clinical record, home's policy, and interviews with staff.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee failed to ensure that someone was available to provide the assistance required by a resident prior to meal being served during supper.

Rationale and Summary
A resident was left unsupervised during a meal and drank fluid not prescribed for them leading to a negative health outcome.

The resident's plan of care stated they required one team member to assist them with eating and their diet order required certain consistency.

The resident was observed unattended and unsupervised in the dining room during lunch meal service. A staff member placed two cups of fluids on their table within reach and walked away.

The Director of Care (DOC) confirmed the resident consumed the wrong fluid consistency and was not supervised at the time of consumption.

By not providing supervision during meal service to the resident they consumed the wrong consistency of fluids that impacted their health.

Sources: Meal observations, home's "Mealtime Responsibilities" policy, resident's clinical records, interviews with staff.

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe

and secure environment for its residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A. Complete a documented review of all residents in one of the home areas to identify those with risk of eloping.
B. Develop and implement a plan and strategy to monitor those residents identified in part A, and to protect them from eloping from the home.
C. Audit weekly to ensure the plan and strategies from part B are being followed and the audit records kept. Include who completed the audit, the dates, and actions taken until the order is complied.
D. Develop a strategy and implement to improve the security of the front door of the home to minimize the risk of residents eloping.

Grounds
The licensee failed to ensure the home was a safe and secure environment for three residents when they eloped from the home on the same day.

Rationale and Summary

A new resident was missing from the home since morning and did not attend lunch meals. Morning staff members were aware but a code yellow for a missing person was not called and the afternoon staff were not informed.

Staff did not follow the home's Missing Person Policy to search for a missing resident.

On the same day, from the same home area, a second resident, was missing after lunch and found by in coming afternoon staff far from the home. The resident's wellbeing had been negatively impacted.

The same day and same home area, a third resident was identified by staff as missing during bedtime. The resident was found by their family member.

Three residents went missing from the same home area on the same day risking their health and safety.

Sources: Resident clinical records, staff interviews, resident interview, Power of Attorney interview, and Schlegel Villages Missing Resident Policy.

This order must be complied with by September 20, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTE 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.