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: October 1, 2024
Inspection Number: 2024-1461-0004
Inspection Type: Critical Incident
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): September 23, 24, 25, 26, 2024.

The following intake(s) were inspected:

- Intake: #00120261 - Critical Incident System (CIS) report #2979-000036-24, related to alleged staff to resident abuse;
- Intake: #00121419 - CIS #2979-000043-24, related to a medication incident;
- Intake: #00123932 - CIS #2979-000053-24, related to a resident altercation;
- Intake: #00125484 - CIS #2979-000058-24, related to an infectious disease outbreak.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication Management System

NC #001 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 home's New Medication Orders policy was complied with and implemented by staff as part of the home's Medication Management System for a resident.

Rational and Summary:
A clinical record review for a resident documented an identified medical condition as part of the resident's past medical history.

During the course of this resident's care and treatment a registered staff member identified that one of the resident's current treatments was contraindicated. They also identified that previous registered staff, while processing certain orders, had not identified that the resident had a medical condition for which this specific treatment was contraindicated. Therefore, the resident's treatment had the potential to negatively impact the resident's medical condition and put the resident at risk of greater medical complications.

A review of the home's pharmacy service provider CareRX policy, New Medication Orders policy #4.2, showed the following:
Section B: Processing prescriber's orders included "Only nursing staff may process a prescriber's order. Check the order for completeness, allergies, and legibility (any concerns with the order must be brought to the attention of the prescriber before processing the order further)."

In an interview with the Director of Care (DOC) and the Assistant Director of Care (ADOC), they both said that staff did not comply with the specific procedure, and they said the expectation was for staff to comply and implement the New Medication Orders policy as part of the home's medication management system.

Sources: record reviews and staff interviews.