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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: June 2, 2023

Inspection Number: 2023-1366-0004

Inspection Type:
Complaint
Critical Incident System

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Erin Meadows, Mississauga

Lead Inspector	**Inspector Digital Signature**
Emmy Hartmann (748)	EmmyLou Hartmann Digitally signed by EmmyLou Hartmann Date: 2023.06.06 13:38:32 -04'00'

Additional Inspector(s)
Betty Jean Hendricken (740884)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 27-28, 2023, and May 1-5, 8-11, 2023.

The following intake(s) were inspected:

- Intake: #00085458, CIS #2881-000011-23, was related to falls.
- Intake: #00003999, CIS #2881-000025-22, was related to medication management.
- Intake: #00022554, was related to a complaint about resident care.
- Intake: #00083788, was related to a complaint about resident care.
- Intake: #00083837, was related to a complaint about resident care.

The following intakes were completed in this inspection:

- Intake: #00003730, CIS #2881-000003-22, was related to falls.
- Intake: #00004468, CIS #2881-000002-22, was related to falls.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
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)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed after a fall resulting in injury.

Rationale and Summary
The resident had a fall resulting in an injury requiring hospital transfer. Prior to the fall, the resident was independent with all transfers and walked independently with their assistive device. The resident returned from hospital and required two persons for transfers and mobility.

An observation of the resident showed them receiving support from two staff for mobility and interviews with staff demonstrated that they were aware of the resident's current care plan interventions.

The resident's care plan identified the resident was independent with all transfers and walked independently with their assistive device. An observation also showed an independent transfer logo above the resident's bed.

Staff updated the care plan.

Sources: A resident's clinical record, staff interviews, CI# 2881-000011-23, observations.

[740884]

WRITTEN NOTIFICATION: Medication Management System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 114 (2)

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 114 (2) of O. Reg. 79/10.

The licensee has failed to comply with their medication management policies developed to ensure the accurate acquisition of drugs.

Rationale and Summary
In accordance with O. Reg 79/10 s.8 (1) b, the licensee was required to ensure the medication management program had in place a procedure for processing physician's orders and must be complied with.

Specifically, staff did not comply with eMAR Order Processing Procedures policy and the Physician's Order policy. As per the Physician's Order policy, phone orders were to be written stating the order was a phone order, naming the physician giving the order, the name of the team leader obtaining the phone order and the date and time the order was received. The physician was required to sign these orders as confirmation on their next visit. As per the eMAR Order Processing Procedures, all orders must be checked by two different nurses (1st and 2nd checks).

On an identified date, a phone order was obtained. There was no time on the order, the order was not checked by a second nurse and was not signed by the physician.

On two identified dates, phone orders were obtained. The orders were not checked by a second nurse and were not signed by the physician.

Sources: Staff interviews, a resident's Physician's DigiOrder, Schlegel Villages eMAR Order Processing Procedures policy, Schlegel Villages Physician's Order policy.

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WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 131 (2)

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s.131 (2) of O. Reg. 79/10.

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

Rationale and Summary
On an identified date, a staff member obtained a telephone order from a physician to give a resident a medication with other interventions.

The staff member confirmed that they did not administer the medication, as prescribed, and only gave the resident the other interventions.

Failure of the staff member to administer the medication, as prescribed could have led to a negative health outcome for the resident.

Sources: Staff interview, a resident's eMAR and MediSystem Prescriber's DigiOrder Sheet.

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WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan was provided to a resident, for falls prevention.

Rationale and Summary
A resident was found on the floor on an identified date. After the incident, a progress note identified that a bed alarm would be implemented for the resident.

However, there was no bed alarm placed on the resident's bed during observations.

The resident did not have any other fall; however, the resident may have been at an increased risk for falls, when not all of the falls prevention interventions were implemented as per plan.

Sources: A resident's progress notes, interview with ADNC.

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WRITTEN NOTIFICATION: Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

A: The licensee has failed to ensure that the provision of care set out in the plan of care was documented for a resident.

Rationale and Summary
On an identified date, a resident had a change in condition requiring medication. The staff assessed the resident and administered the medication; however, they failed to document the results of their assessment and failed to enter the medication into the electronic medication administration record (eMAR).

Failure to document the assessment and administration of the medication could have led to a negative health outcome for the resident.

Sources: A resident's clinical record, staff interviews.

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B: The licensee has failed to ensure that the provision of treatment to a resident was documented.

Rationale and Summary
A resident was noted to have had a change in condition. A nurse and nurse practitioner (NP) assessed the resident and decided to send the resident to the hospital. The NP identified that a treatment was provided to the resident prior to being transferred to the hospital; however, there was no documentation that the treatment was provided.

Sources: A resident's progress notes; interview with NP.

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C: The licensee has failed to ensure that documentation for the post-fall assessment and communication with the doctor, related to a resident's fall, was completed.

Rationale and Summary
A resident was found on the floor on an identified date. The RPN identified that they assessed the resident, and suspected an injury. They called the doctor, who provided them with specific instructions related to the transfer to the hospital.

The RPN verified that they did not document their assessment of the resident after the resident fell, and did not document the call to the doctor and the instructions provided.

Sources: A resident's progress notes, assessments; interviews with RPN.

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WRITTEN NOTIFICATION: Inclusion in plan of care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 1.

The licensee has failed to ensure that alternatives to the use of a Personal Assistance Services Device (PASD) was considered for a resident.

Rationale and Summary
A resident was observed to have a physical device.

The assessment on admission related to the physical device identified that it was implemented for the resident as a PASD. According to the assessment, there were no alternatives trialed for the physical device.

The home's policy stated that the team needed to consider and evaluate alternatives to the use of a physical device in collaboration with the resident/ Substitute Decision Maker (SDM) before considering the use of the physical device on the resident.

The MDS-RAI coordinator verified that they completed the assessment for the physical device for the resident on admission, and alternatives for the physical device were not considered prior to implementation.

Sources: Observation of a resident; a resident's assessments; the home's Restraint and PASD Procedures in LTC policy; interviews with the RAI-MDS coordinator, and DNC.

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WRITTEN NOTIFICATION: Binding on licensees

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

A: The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out a Minister’s Directive, that it was complied with.

In accordance with the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, the licensee was required to ensure that (A) (B) (C) (D) of the directive were adhered to. (A) Training, (B) The use of glucagon, (C) Severe hypoglycemia or unresponsive hypoglycemia, and (D) Reporting Requirements specifically as it related to the documentation, review, and analysis; quarterly evaluation; and annual evaluation sections of the directive.

Rationale and Summary
The Minister's Directive stated that every licensee of a long-term care home shall ensure that all direct care staff received training on the requirements of the directive.

The home's pharmacy service provider, MediSystem, held one training session on Glucagon Use and Hypoglycemia on August 30, 2022. The in-service sign-in record had fourteen staff signatures. The DNC confirmed that all direct care staff have not received training on the requirements of the Directive.

The Minister's Directive stated the use of glucagon needed to be reported to the resident, the resident's substitute decision-maker, if any, the DNC, the Medical Director, the prescriber of the glucagon, the resident's attending physician or the registered nurse (RN) in the extended class attending to the resident, and the pharmacy service provider.

On an identified date, it was documented that a resident was administered glucagon. There was no documentation that the Medical Director was notified.

On the occasion where glucagon was administered to the resident, and where the same resident was transferred to the hospital, due to severe and unresponsive hypoglycemia, there was no documentation, review, and analysis as it related to B. 2. (2)(a)(b)(c) of the Minister's Directive and there was no evidence of a quarterly evaluation or an annual evaluation in its entirety as set out in the Minister's Directive for B. and C.

The licensee did not have any documented evidence to show their compliance with keeping records, reviewing, analyzing, and evaluating the use of glucagon for hypoglycemia for a resident that resulted in transfer to hospital as defined in the Minister's Directive and the homes policy.

The Minister's Directive further stated that the licensee shall ensure that the Director was informed of a resident who was administered glucagon which resulted in the resident being taken to a hospital, no later than one business day after the occurrence of the incident. The incident on an identified date was not reported to the Director, until two days after.

Further, Section D (3) (4) of the Minister's Directive stated that the report to the Director was required

to have an analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence. There was no evidence of analysis or follow-up action on the Critical Incident report submitted to the Director.

Sources: Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, (Updated April 11, 2022), a resident's clinical records, home's policy titled "Hypoglycemia and Glucagon" tab 05-17 (created August 4, 2014), Professional Advisory Committee (PAC) meeting minutes (August 4, 2022), Medication Incident Report #MIR-36205, Interviews with staff, Schlegel Villages In-Service Sign-in record, CI# 2881-000025-22.

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B: The licensee has failed to carry out every operation or policy directive that applied to the long-term care home.

Rationale and Summary
According to the Minister's Directive: COVID-19 response measures for long-term care homes, licensees were to ensure that covid 19 screening requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, were followed.

The COVID-19 Guidance Document for long-term care homes in Ontario, stated that homes must ensure that all residents were assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.

A review of a resident's records for an identified month, revealed that they did not have their temperatures taken daily.

A registered nurse (RN) verified that the resident's temperatures were not taken daily.

The resident exhibited symptoms for three days during the identified month, and there was a risk that the progression of symptoms would not be detected as the resident's temperature was not taken daily.

Sources: A resident's progress notes, weights and vitals in PCC; Minister's Directive, effective August 30, 2022; COVID-19 Guidance Document for long-term care homes in Ontario, October 14, 2022; interviews with an RN, and DNC.

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WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26

The licensee has failed to ensure that a resident's bed was used as per manufacturer's instructions.

Rationale and Summary
A resident was found on the floor on an identified date. Prior to this, the resident was laying on their bed. The PSW and nurse that responded to the resident's fall identified that the locks on the resident's bed, were not applied.

The manufacturer's instructions for the resident's bed identified that the floor locks increased bed stability and resident safety, and that locks must be engaged prior to the use of the bed.

The home's Director of Environmental Services (DES) identified that the manufacturer's instructions for the bed outlined that the lock should be engaged when the resident was in bed, and that staff are trained to follow this.

Although, the resident's fall was not witnessed, the locks not being applied while the resident was in bed could have contributed to the resident's fall where they sustained an injury.

Sources: A resident's progress notes; Joerns Bed Frames Care 100 User Manual; interviews with a PSW, RPNs, DES, and DNC.

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WRITTEN NOTIFICATION: Policy to minimize restraining of residents, etc.

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 118 (a)

The licensee has failed to comply with the home's written policy regarding the use of a physical device.

Rationale and Summary
In accordance with Ontario Regulation 246/22 s.11. (1) b, the licensee was required to ensure that the

home's written policy under section 33 of the Act dealt with, the use of physical devices, and must be complied with.

Specifically, staff did not comply with the home's policy which outlined that assessments for a physical device was to be completed quarterly in Point Click Care (PCC).

A quarterly assessment scheduled on an identified month was missing, and the RAI-MDS coordinator, verified that the assessment for the physical device was not completed on a quarterly basis.

Sources: A resident's assessments; the home's Restraint and PASD Procedures in LTC policy; interview with MDS-RAI Coordinator.

[748]

WRITTEN NOTIFICATION: Administration of Drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The licensee has failed to ensure that a drug administered to a resident had been prescribed for the resident.

Rationale and Summary
On an identified date, a resident required medication after they had a change in condition. A review of the progress notes, stated that the medication was given to the resident.

The resident's Prescriber's Digiorders found no order for the administration of the medication.

Failure to ensure the medication was ordered prior to being administered could have negatively affected a resident's health.

Sources: A resident's clinical records, staff interviews, home's policy titled "Hypoglycemia and Glucagon" PCS04-006 (created August 4, 2014), CI# 2881-000025-22.

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