Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under *the Long-Term Care Homes Act, 2007*

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 06, 2022	2021_788721_0018 (A3)	010422-21, 010423-21, 014046-21, 014155-21, 014969-21, 015201-21, 015254-21, 017479-21	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

The Village of Glendale Crossing
3030 Singleton Avenue London ON N6L 0B6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by MEAGAN MCGREGOR (721) - (A3)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 2-5, 8-10, 15 and 16, 2021.

The following Critical Incident System (CIS) intakes were inspected during this inspection:

Log #014046-21, CIS #2979-000054-21 related to falls prevention and management;

Log #014155-21, CIS #2979-000055-21 related to falls prevention and management;

Log #014969-21, CIS #2979-000058-21 related to falls prevention and management;

Log #015201-21, CIS #2979-000061-21 related to allegations of neglect and skin and wound care;

Log #015254-21, CIS #2979-000059-21 related to falls prevention and management; and

Log #017479-21, CIS #2979-000063-21 related to an incident of resident to resident physical abuse.

The following Follow-Up intakes were also inspected during this inspection:

Log #010422-21 related to Compliance Order (CO) #002 from Previous Inspection #2021_605213_0016 regarding O.Reg 79/10, s. 114. (3) with a Compliance Due Date (CDD) of September 30, 2021; and

Log #010423-21 related to CO #001 from Previous Inspection

#2021_605213_0016 regarding LTCHA, s. 19. (1) with a CDD of September 30, 2021.

During the course of the inspection, the inspector(s) spoke with the General Manager, the Assistant General Manager, the Director of Care (DOC), two Assistant Directors of Care (ADOCs), a Neighbourhood Coordinator, a Resident Assessment Instrument (RAI) Coordinator, an Exercise Therapist, the Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a PSW student, housekeeping staff, screeners and residents.

During this inspection an Infection Prevention and Control (IPAC) observational checklist was completed.

The Inspectors also toured the home and observed IPAC practices in place and the care being provided to residents; reviewed clinical records and plans of care for the identified residents; and reviewed policies, procedures and documentation related to the incidents and CO's.

This inspection was conducted concurrently with Complaint Inspection #2021_788721_0019.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.

- **3 WN(s)**
- **1 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 114. (3)	CO #002	2021_605213_0016	721

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #012 was protected from physical abuse by resident #013.

O. Reg. 79/10, s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

The Schlegel Villages policy titled "Personal Expression Program" indicated that the term Personal Expressions was used to describe how a person living with cognitive concerns communicates something important to them about their personal, social or physical environment.

An incident occurred where resident #013 physically abused resident #012 which resulted in resident #012 sustaining an injury.

Resident #013's care plan indicated they had a history of physical personal expressions towards others and directed staff to use specific strategies and interventions to minimize their personal expressions. They were also identified to be on the Personal Expressions Response Team (PERT) active caseload prior to this incident.

Resident #013's progress notes and incident reports under their assessments section in Point Click Care (PCC) documented three previous incidents in the six month period prior to this incident where they had exhibited physical personal expressions towards other residents and staff in the home.

A PSW said resident #013 had a history of physical personal expressions and identified specific triggers for their personal expressions. They recalled that at the time of this incident specific interventions were in place for resident #013 related to their personal expressions and the physical abuse that occurred towards resident #012 was unprovoked.

A PERT staff member indicated it was the responsibility of PERT to follow-up with any residents who have personal expressions that are challenging to manage and any incident involving a physical altercation with residents. They said they were responsible for assessing residents on the PERT caseload and working with staff on the neighbourhood to identify triggers and develop strategies and interventions for minimizing their personal expressions. Eight days after the incident occurred, they confirmed they had not been made aware of the incident that occurred where resident #013 physically abused resident #012. They said that resident #013 had a previous history of physically abusing residents but most of their recent incidents of physical personal expressions had been directed towards staff. They said they hadn't yet re-evaluated the effectiveness of the interventions in place to manage resident #013's personal expressions and protect other residents from physical abuse as they were not previously aware of the incident.

The General Manager confirmed that PERT should have been notified of the incident that occurred where resident #013 exhibited physical personal expressions towards resident #012 and that they considered this incident to have been physical abuse.

Resident #012 was physically abused by resident #013 after the home was aware that there was risk of resident #013 exhibiting physical personal expressions towards other residents and internal reporting protocols were not implemented to ensure a follow-up reassessment had occurred for resident #013 to identify triggers for their personal expressions and evaluate strategies and interventions in place to minimize their personal expressions, which may have put other residents at future risk of harm due to incidents of physical personal expressions by resident #013.

Sources: Review of the CIS report, Schlegel Villages "Personal Expression Program" policy, resident #012 and #013's progress notes, incident reports, assessments and care plans in PCC; observations of resident #012 and #013, and staff interviews with a PSW, a PERT RPN, the DOC and the General Manager. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, were assessed by a registered dietitian who was a member of the staff of the home and were reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

The Schlegel Villages policy titled "Skin and Wound Care Program" indicated that it was the responsibility of registered nursing staff to assess altered skin integrity including skin breakdown, pressure injuries, skin tears and wounds weekly and to refer these areas of altered skin integrity to the dietitian using the dietitian referral form. They were to document these assessments by completing a “PRN Skin Assessment UDA” or using the skin and wound application tool in PCC when there was a change in skin integrity and weekly thereafter until the wound was healed.

An RN explained that registered nursing staff on each neighbourhood were responsible for assessing any areas of altered skin integrity that a resident had by taking a photo of the area in the skin and wound application tool and then completing the “Skin & Wound Evaluation” which was generated under the assessments section in PCC. They said that a “Skin & Wound Evaluation” would

be completed for any new area of altered skin integrity and once this initial assessment had been completed an alert would auto-populate in PCC reminding staff to complete a reassessment of the area every seven days. The RN said registered staff would also notify the RD of any new areas of altered skin integrity by completing a dietitian referral under the assessments section in PCC.

A) The licensee failed to ensure that when resident #002 exhibited altered skin integrity they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, were assessed by a registered dietitian who was a member of the staff of the home and were reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

i) It was identified that resident #002 had a specific area of altered skin integrity and an initial “Skin & Wound Evaluation” was completed under the assessments section in PCC related to this area of altered skin integrity.

During the 15 weeks that they had this specific area of altered skin integrity there was no weekly “Skin & Wound Evaluation” related to this area of altered skin integrity completed on nine of the 15 weeks.

ii) It was documented that resident #002 had a specific area of altered skin integrity. It was noted that the physician would be updated on rounds and treatment orders were implemented on this same date.

There was no “Skin & Wound Evaluation” completed under the assessments section in PCC for this specific area of altered skin integrity. A“Skin & Wound Evaluation” was completed related to another area of altered skin integrity, 22 days after this area of altered skin integrity was identified. The photos taken as part of this “Skin & Wound Evaluation” and subsequent assessments for this other area of altered skin integrity showed this area of altered skin integrity.

There was no initial “Skin & Wound Evaluation” related to this specific area of altered skin integrity completed until 22 days after it was first identified. After the initial “Skin & Wound Evaluation” had been completed, there was no weekly “Skin & Wound Evaluation” related to this area of altered skin integrity completed on one of the five weeks that followed when they had this area of altered skin integrity, and no documentation indicating that the RD was notified of this area of altered skin integrity.

The RD explained that they were to be notified of any new or worsening areas of altered skin integrity by receiving a dietitian referral under the assessments section in PCC. They confirmed that they did not receive a dietitian referral and were not notified of this new area of altered skin integrity and would expect that they should have been notified.

The DOC confirmed that when resident #002 exhibited this new area of altered skin integrity an initial skin assessment of this wound was not completed until 22 days later, in which the location of this area of altered skin integrity was incorrectly identified, this area of altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff on one of the five weeks that they had the area of altered skin integrity following the initial skin assessment, and the RD was not notified of this area of altered skin integrity. They said they would expect an initial assessment of this area of altered skin integrity should have be completed when it was first identified, with reassessments completed weekly thereafter and that the RD should have been notified of this area of altered skin integrity.

B) The licensee failed to ensure that when resident #003 exhibited altered skin integrity they were reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

It was identified that resident #003 had a specific area of altered skin integrity and a “Skin & Wound Evaluation” was completed under the assessments section in PCC related to this area of altered skin integrity.

During the three weeks that they had this area of altered skin integrity there was no weekly “Skin & Wound Evaluation” related to this area of altered skin integrity completed on two of the three weeks.

C) The licensee failed to ensure that when resident #012 exhibited altered skin integrity they were reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

It was identified that resident #012 had two specific areas of altered skin integrity. On the date these areas of altered skin integrity were first identified it was noted that staff were unable to get photos for the skin and wound assessment during care and this would be endorsed to the following shift. An initial "Skin & Wound

Evaluation" was completed under the assessments section in PCC related to each of these areas of altered skin integrity two days later.

During the two weeks that they had these two areas of altered skin integrity there was no weekly “Skin & Wound Evaluation” related to these areas of altered skin integrity completed on one of the two weeks.

Completing initial and weekly skin assessments using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments and referring areas of altered skin integrity to the RD for assessment ensure that the progression of any areas of altered skin integrity are being monitored and evaluate the effectiveness of interventions in place to reduce or relieve pain, promote healing, and prevent infection.

Sources: Review of Schlegel Villages "Skin and Wound Care Program" policy, and resident #002, #003 and #012’s progress notes, assessments, skin and wound application tool, and care plans in PCC; and staff interviews with an RN, the RD and the DOC. [s. 50. (2) (b) (i)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A3)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).
(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that internal reporting protocols developed to meet the needs of residents with responsive behaviours were co-ordinated and implemented on an interdisciplinary basis for resident #013.

In accordance with O. Reg. 79/10, s. 53(1)4 the licensee was required to ensure that internal reporting protocols were developed to meet the needs of residents with responsive behaviours.

The Schlegel Villages policy titled "Personal Expression Program" indicated that the term Personal Expressions was used to describe how a person living with cognitive concerns communicates something important to them about their personal, social or physical environment. This policy outlined the procedure to be followed if an incident occurs related to personal expressions. Staff were directed to initiate the “Personal Expressions Neighbourhood Observation Tool” in PCC following an incident as soon as the environment was safe and prior to the end of their shift. After this tool has been completed the “PERT Assessment” in PCC may be initiated by the registered team member, and the registered team member with the support from their leadership team and PERT will begin to determine the level of risk of the incident that had occurred prior to the end of their shift.

An incident occurred where resident #013 physically abused resident #012.

Resident #013’s care plan indicated they had a history of physical personal expressions towards others and they were identified to be on the PERT active caseload prior to this incident.

There was no “Personal Expressions Neighbourhood Observation Tool” or “PERT Assessment” completed in PCC following the incident and no documentation indicating that any follow-up had occurred to determine the level of risk of the incident.

A PERT staff member indicated it was the responsibility of PERT to follow-up with any residents who have personal expressions that are challenging to manage and any incident involving a physical altercation with residents. They said they were responsible for assessing residents on the PERT caseload and working with staff on the neighbourhood to identify triggers and develop strategies and interventions for minimizing their personal expressions. Eight days after the incident occurred, they confirmed they had not been made aware of the incident that occurred where resident #013 physically abused resident #012. They said resident #013 was already on the PERT active caseload prior to this incident and they would usually follow-up with them on PERT rounds twice per month but that they would expect they should have been notified of the incident sooner by email or via a "PERT Assessment" referral in PCC.

The General Manager confirmed that PERT should have been notified via email or a "PERT Assessment" referral in PCC related to this incident.

As a result of internal reporting protocols not being implemented, PERT was unaware of the incident and a follow-up reassessment had not occurred to identify behavioural triggers and evaluate strategies and interventions in place to minimize their personal expressions, which may have put other residents at future risk of harm due to incidents of physical personal expressions by resident #013.

Sources: Review of the CIS report, Schlegel Villages "Personal Expression Program" policy, resident #013’s progress notes, care plan and assessments in PCC and their physical chart; and staff interviews with a PSW, a PERT RPN, the DOC and the General Manager. [s. 53. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, for all programs and services, the matters referred to in subsection (1) are co-ordinated and implemented on an interdisciplinary basis, to be implemented voluntarily.

Issued on this 6 th day of January, 2022 (A3)

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.