Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 6, 2016	2016_277538_0025	023986-16	Complaint

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

NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 21, 22, 26, 2016.

This complaint inspection IL-46083-LO was related to reporting certain matters to the Director, resident bill of rights, continence care and bowel management, dining and snack service and duty to protect.

During the course of the inspection, the inspector(s) spoke with the Interim General Manager, General Manager, Director of Nursing, two Neighbourhood Co-ordinators, five Personal Support Workers, one Physician, two Registered Practical Nurses, Director of Nutritional Services, one Registered Nurse, one Cook, one identified resident and two family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Legendé 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 O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of, a between-meal beverage in the morning.

A review of the nutrition and hydration flow sheet for a specified period of time, indicated fluid intake between breakfast and lunch for an identified resident was zero percent during 70 of 120 days. Further review revealed documentation indicating that the resident was sleeping during morning snack service, 48 of the days.

Review of the plan of care revealed that the identified resident required total assistance for all activities of daily living (ADL's). There were interventions in place to promote fluid intake.

A review of the home's nutrition and hydration policy stated, "Additional fluids will be encouraged at each meal and via the tea cart(s) by all team members in order to increase fluid consumption for those at risk or below their individual requirements."

A Personal Support Worker (PSW) acknowledged that they had not offered the identified resident a beverage during the morning, stating that "resident usually declines anyway."

Staff interviews with a PSW and a Registered Nurse (RN) acknowledged that no attempts were made to rouse the resident when they appear to be sleeping during morning snack service(s).

Interviews with the Director of Care (DOC), Interim General Manager (ITM) and the General Manager (GM), all agreed the expectation was that each resident should be offered a beverage in the morning. [s. 71. (3) (b)]

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 the residents are offered a minimum of, a between- meal beverage in the morning, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse.

During an interview with an identified resident's family member, it was acknowledged that poured medications were handed to them for administration to the resident and registered staff do not stay in the room until the resident swallowed the prescribed medications.

A review of the physician orders revealed no documented evidence of an order for anyone other than registered staff to administer the resident's medication.

Review of the home's policy titled Medication Administration Pass, policy number 4.6, dated as effective September 1, 2013, stated that "a staff member administering a medication was to remain with the resident until the medication had been swallowed."

Interviews with the Director of Care (DOC) and Registered Nurse (RN) acknowledged that when administering medications to the identified resident they leave the medications with the resident's family member and have not remained with the resident until the medication has been swallowed. Both the DOC and RN agreed that they have signed that the medications were taken without witnessing that the resident has swallowed them.

Interviews with the DOC and the General Manager (GM) agreed that no person should administer a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse. [s. 131. (3)]

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 no person administers a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.

Issued on this 18th day of October, 2016

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

Original report signed by the inspector.