Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 6, 2019	2019_536745_0019	009972-19, 011756-19	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

CHERYL MCFADDEN (745), MELANIE NORTHEY (563)

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): July 22, 23 and 24, 2019.

The following Critical Incident (CI) intakes were completed within this inspection:
Log #009972-19 / CI #2979-000063-19 related to falls prevention.
Log #011756-19 / CI #2979-000068-19 related to improper transferring of resident.

The following complaint intake was completed within this inspection:
Log #011885-19 / IL67576-LO related to improper transferring of resident resulting in a fall.

During the course of the inspection, the inspector(s) spoke with the Director of Recreation, the Administrative Assistant, the Falls Lead/Exercise Therapist, a Registered Nurse, Personal Support Workers, a Power of Attorney and residents.

The inspectors also made observations of residents, activities and care. Relevant policies and procedures, incident reports, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The Critical Incident Report submitted to the Ministry of Health and Long Term Care (MOHLTC) documented an incident involving a resident.

The MOHLTC Infoline - Complaint Information Report documented the concerns reported by resident Power of Attorney (POA). The POA reported that the resident was provided a transfer technique that was improper.

The Fall Incident progress note in Point Click Care (PCC) documented the resident had a fall due to improper transfer technique.

The Weekly Skin Observation Tool - SV2 - V 2 documented the resident had multiple areas of altered skin integrity.

The Falls Incident Report-SV - V 4 documented that PSW staff were performing a transfer of the resident and the assistive device in use contributed to the fall.

The Schlegel Villages Mechanical Lifts policy stated, "Place the sling in the appropriate place under the resident". "The assistant should support the resident and ensure appropriate sling application. If the resident is off balance, lower the lift and reposition them." "Ensure the resident is comfortable, safe and well supported."

The Personal Support Worker (PSW) stated the transfer of the resident resulted in a fall and injury and the PSW verified that staff did not use safe transferring and positioning techniques when assisting the resident using a mechanical lift.

The Exercise Therapist (ET) verified that the PSWs did not use safe transferring and positioning techniques when assisting the resident.

The licensee failed to ensure that PSW staff used safe transferring and positioning techniques when assisting the resident when using a mechanical floor lift.

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 7th day of August, 2019

[redacted]

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

Original report signed by the inspector.