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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Nov 17, 2020	2020_722630_0030	021482-20, 021777-20	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

AMIE GIBBS-WARD (630)

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): November 10 and 12, 2020.

The following intakes were completed within this inspection:

Complaint Log #021777-20 related to continence care, personal support services and the prevention of staff to resident abuse or neglect.

Critical Incident System (CIS) Log #021482-20 / CI 2979-000064-20 related to the prevention of staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the acting Director of Care (DOC), Neighbourhood Coordinators, a Registered Practical Nurses (RPN), a Personal Support Worker (PSW) and a resident's Substitute Decision Maker (SDM).

The inspector also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed procedures of the home, reviewed written records related to the home's internal investigation and reviewed a CIS report.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's written plan of care set clear directions to staff regarding the resident's continence care needs.

The resident's Substitute Decision Maker (SDM) brought forward a specific care concern to staff. This concern had previously been raised by the SDM to the staff and management in the home. The home's staff and leadership team assessed and investigated the care concern. It was determined that the resident could experience discomfort related to the care that was provided on the date of the concern, but the staff had not intentionally provided care in a way to cause discomfort. The resident required specific continence care from staff and the staff were responsible to ensure the care was provided in a way which ensured the resident was comfortable. The plan of care did not provide clear direction for staff regarding the resident's continence care needs.

Sources: Interview with the resident's SDM; interview with a Registered Practical Nurse (RPN) and other staff; review of a Critical Incident System report; a Resident/Family Complaint Response Form; the resident's clinical records including care plan; observations on November 10 and 12, 2020. [s. 6. (1) (c)]

Issued on this 23rd day of November, 2020

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

Original report signed by the inspector.