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
Jan 11, 2021	2020_648741_0022	020830-20, 020831-20, 023607-20, 024312-20, 024814-20, 000084-21	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

AYESHA SARATHY (741), AMIE GIBBS-WARD (630), RHONDA KUKOLY (213)

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): December 21, 22 and 23, 2020, and January 4, 2021

Within this inspection, the following intakes were inspected:

Follow-Up Inspection (FUI) for Compliance Order (CO) #001 from inspection #2020_722630_0022 related to plan of care based on an assessment of the resident's needs and preferences.
Follow-Up Inspection (FUI) for Compliance Order (CO) #002 from inspection #2020_722630_0022 related to plan of care provided as specified in the plan
Critical Incident System (CIS) #2979-000001-21 related to falls prevention and management
Critical Incident System (CIS) #2979-000074-20 related to falls prevention and management
Critical Incident System (CIS) #2979-000075-20 related to falls prevention and management
Complaint IL-85060-LO related to medication management

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), a Registered Nurse (RN), the Exercise Therapist, the Personal Expressions Response Team (PERT) Team Lead, a Neighbourhood Coordinator, an Assistant Director of Care (ADOC), the Director of Care (DOC), the General Manager and residents.

The Inspectors also reviewed clinical records of residents, the home's investigative notes, relevant policies and procedures and observed residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Responsive Behaviours

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

- **3 WN(s)**
- **0 VPC(s)**
- **0 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (2)	CO #001	2020_722630_0022	630
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2020_722630_0022	630

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's needs changed related to their fall prevention interventions.

A resident had an un-witnessed fall that resulted in an injury. The resident's family had requested to make a change to one of the resident's fall interventions three months prior to the fall. At the time of this inspection, the resident's care plan indicated that it had not been revised to reflect the change the family requested.

On one occasion during the inspection, that particular falls intervention was observed not to be in place as was requested by the family.

The Exercise Therapist said that the resident required that particular falls intervention to be in place in the manner that it was requested by their family as they were at risk for falls. They Exercise Therapist and the Director of Care (DOC) said that the resident's plan of care should have been updated to reflect the change in a timely manner.

There was a risk that the resident could have had another fall as a result of their plan of care not being revised when they required a change to their falls interventions.

Sources: Critical Incident System report; the resident's clinical record, including progress notes and care plan; observation of the resident; interviews with the Exercise Therapist, DOC and other staff.

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 :

The licensee has failed to ensure that when a resident 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.

A resident had a fall that resulted in them sustaining an area of altered skin integrity. The area of altered skin integrity was treated at the time of the fall, however, there was no documented evidence that the resident's skin was assessed at that time.

A Registered Practical Nurse (RPN) said that the process for assessing a resident with altered skin integrity was that they would take a photo of the area, cleanse and dress it, complete a skin and wound assessment on their tablets, make a referral to the skin care lead and make an order for the treatment and dressings in the electronic Treatment Administration Record (TAR). They said that there was no skin assessment completed for the resident’s area of altered skin integrity and that it should have been completed when it was first identified.

There was a risk that the resident’s skin could have worsened as a result of staff failing to complete a skin assessment when the area of altered skin integrity was first identified.

Sources: Fall Incident Report; Skin and Wound Evaluations under the Assessment tab in Point Click Care (PCC); interviews with an RPN and other staff.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

The licensee has failed to comply with Compliance Order (CO) #001 from Inspection #2020_722630_0022 served on October 15, 2020 with a compliance due date (CDD) of November 15, 2020. The home failed to ensure that the plan of care for a resident was based on a documented assessment of the resident and their needs related to responsive behaviours. The General Manager acknowledged that part of CO #001 was missed by the management of the home when they developed their compliance action plan.

The resident had an intervention in place for responsive behaviours which was documented in a Personal Expressions Response Team (PERT) assessment, however, there were no other documented assessments indicating whether the resident required the intervention. In addition, the resident's plan of care did not include direction for staff on what they were required to do regarding the intervention.

Sources: CO #001 from #2020_722630_0022; the home's November 2020 compliance action plan; the resident's care plan and other clinical records; interview with the General Manager and other staff.

Issued on this 12th day of January, 2021

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

Original report signed by the inspector.