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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 4, 2013	2013_186171_0005	L-000077-13	Resident Quality Inspection

Licensee/Titulaire de permis

~~THE HOMEWOOD CORPORATION~~ Schlegel Villages Inc.
~~150 DELHI STREET, GUELPH, ON, N1E-6K9~~ 325 Max Becker Dr. Suite 201, Kitchener, ON

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

ELISA WILSON (171), CAROLE ALEXANDER (112), JOAN WOODLEY (172)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 5,6,7,8,11,12,13,14, 2013.

During the course of the inspection, the inspector(s) spoke with the General Manager, Director of Nursing (DON), Assistant Director of Nursing, Director of Environmental Services, Director of Food Services, Director of Recreation, Registered Dietitian, Kinesiologist, Physiotherapist, Neighbourhood Coordinators, Dietary Aides, Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Nurses, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and Family members of Residents.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas and care provided to residents, reviewed medical records and plans of care for identified residents, reviewed policies and procedures of the home, and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The Licensee had not ensured that the Pain Management Policy, effective December 2010, was complied with.

A review of documentation revealed the weekly pain assessment tool was not being used weekly as per policy for an identified resident.

Staff interview with the Director of Nursing revealed the home's expectation was the weekly pain assessment tool would be completed as well as a pain assessment note in the progress notes. Registered staff were also expected to initial in the Medication Administration Record (MAR) that the assessment had been completed as per current policy. [s. 8. (1)]

2. The licensee had not ensured the interdisciplinary restorative care program required under the Act was implemented. A policy had been prepared and home management indicated it would be implemented in the near future. [s. 8. (1) (a)]

3. The licensee had not ensured the policy regarding weight monitoring was complied with.

a) One resident's weight was listed in pounds on the hardcopy record sheet that the PSW completed when the resident's weight was taken. The policy stated weights will be recorded in kilograms. (172)

b) The Home's policy indicated weights would be taken and recorded monthly for all residents. However when records were checked on February 6, 2013 the weights for January 2013 were missing for six of the 15 residents reviewed.

Staff confirmed weights were expected to be completed monthly in kilograms and that the weights for the above residents were missing. [s. 8. (1) (b)]

4. The licensee had not ensured that the policy regarding catheter care was complied with.

The Catheter Care Policy (04-24) indicated "catheter output recording should be done every shift, indicating amount, colour and consistency". A review of documentation revealed this was not being completed on a regular basis.

[s. 8. (1) (b)]

5. The licensee had not ensured the policy regarding a post-fall head injury routine was complied with.

A review of documentation revealed the Neurological/Head Injury Vital Signs Record was not always used after unwitnessed falls as per policy. Also a review of progress notes revealed staff were not documenting electronically twice per shift for residents on a head injury routine.

Staff confirmed a head injury routine should be started after unwitnessed falls and that the Neurological/Head Injury Vital Signs Record should be used. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The Home did not have a written description of the quality management system that included its goals, objectives, policies, procedures and protocols.

The food services department participated in food committee meetings and completed various audits, however there were no documented goals, objectives, policies, procedures or protocols in place regarding their quality management system. There was no documentation provided to indicate how food services analyzes, evaluates and improves the quality of their services based on the information they collect in audits and meetings.

During resident and family member interviews completed during this inspection, nine out of twenty-three (39%) had complaints or concerns about the food services, including food quality, taste, temperature and the table set with dirty dishes. There were also concerns expressed regarding how the meals were served, including staff reaching in front of residents, table cloths being removed while residents were still seated at the table and desserts being served before entrees were finished.

The Food Service Director confirmed a process was not in place and that there were no surveys or audits completed that would evaluate the resident's satisfaction with the quality and taste of the food offered. [s. 228. 1.]

2. The licensee had not ensured the quality improvement review system included communication to the Residents' and Family Councils on an on-going basis of improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents.

This was confirmed by a review of the minutes of the Council meetings and interview with the home's management. [s. 228. 3.]

3. The licensee had not ensured the names of the persons participating in evaluations and the dates improvements were implemented were documented.

The food services department had made some improvements in care and services such as making menu changes as per resident requests; however the dates and persons involved in the evaluation were not documented. This was confirmed by the Director of Food Services. [s. 228. 4. ii.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 the quality improvement review system includes communication to the Residents' and Family Councils on an on-going basis of improvements made to the quality of the accommodation, care, services, programs and good provided to the residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure every resident's right to be treated with courtesy and respect that fully recognized the resident's individuality and respected the resident's dignity.

An identified resident had made requests for assistance on a number of occasions. The responses from staff regarding their unavailability to assist at those times upset the resident.

Management of the home confirmed that the responses were not considered courteous or respectful. [s. 3. (1) 1.]

2. The Licensee had failed to ensure the confidentiality of personal health care information for those residents residing in the home.

Critical incident reports, containing personal health care information about residents, were in a binder located on a handrail on the Main Street of the home. This binder also contained the Ministry of Health and Long Term Care (MOHLTC) public inspection reports and orders for the last two years.

Staff interview with the Director of Care confirmed this binder was posted on their Main Street. All critical incident reports were subsequently removed at the time of this inspection and the binder reposted with just the public copies of the MOHLTC public inspection reports. [s. 3. (1) 11. iv.]

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 resident's rights are fully respected and promoted with regards to treating residents with courtesy and respect and ensuring confidentiality, to be implemented voluntarily.

WN #4: 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 had not ensured the written plan of care provided clear direction to staff and others providing direct care to the residents.

An identified resident's diet order changed which included an updated dietary restriction. The diet card in the binder in the servery had been updated to reflect the change, however the detailed instructions regarding how much to serve at each meal and snack had not changed. The food and fluid records indicated the resident took 10-50% more than allowed of the restricted item after the diet change and staff indicated they did not have clear direction regarding how much to offer at each meal and snack.

Staff confirmed the detailed listing of amounts to be served at each meal and snack needed to be updated. [s. 6. (1) (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 clear direction is provided to staff in the written plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The Licensee had failed to ensure the resident-staff communication and response system was on at all times.

On February 7, 2013, in one neighbourhood, the staff pocket pagers were not working properly and the audible speakers were not activated. The PSW's were relying on the system's light outside a room to know if a resident was requiring assistance. Not all outside room call lights would be visible to a PSW due to the design of the resident home area.

This resident-staff communication and response system failure was confirmed by a Personal Support Worker, the Environmental Service Manager and the General Manager. [s. 17. (1) (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 the communication and response system is on at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee had not ensured all planned menu items were available and offered to the residents.

The appropriate vegetable for a special diet order was not available at a lunch meal and a resident was then served a menu item which was not allowed on the special diet.

Staff confirmed the menu item had not been prepared for this meal. [s. 71. (4)]

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 all planned menu items are available and offered to the residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee had not ensured that all foods were served using methods to preserve nutritive value.

At a lunch meal service in one neighbourhood the following was noted: mixed vegetables were served using a #12 scoop instead of a #8 scoop (equivalent to receiving 1/3 cup instead of 1/2 cup serving) and all sandwiches were served as a half on white bread instead of a whole on brown bread. This resulted in the nutritive value for these meals to be altered.

Staff confirmed the posted servings sizes should have been used and if a resident wants half portions on a regular basis this would need to be assessed and care planned by the Registered Dietitian. [s. 72. (3) (a)]

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 all food are served using methods to preserve nutritive value, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee had not ensured the home's dining service included sufficient time for every resident to eat at his or her own pace.

a) Physiotherapy Assistants (PTAs) came into one of the dining rooms half an hour after the lunch meal service started to get residents to leave and attend exercise sessions. PSW's stopped them as the residents had not finished their entrees or had their desserts.

PSW's indicated this happens frequently and the residents then feel rushed and confused as to what they should do, stay and eat or leave for exercises.

PTA's shared the residents eat between 1200 and 1300 at which time they ask the residents if they want to go to exercises; however observations made on one day revealed lunch started at 1230 and finished around 1330. (172)

b) It was noted during resident interviews that residents have felt rushed to finish their dinners when staff ask them about dessert while still eating their entrees or when the tables are cleared, including tablecloths, while they are still finishing their meal and/or have not left the table. An observation of dinner meal service in one neighbourhood confirmed that the tablecloths were removed from two tables while residents were still at the table.

Management staff confirmed that the tablecloths should not be removed while the residents are still at the table to ensure residents are not feeling rushed to finish their meal and leave the dining room. [s. 73. (1) 7.]

2. The licensee had not ensured meals were served course by course. In one neighbourhood during the lunch meal desserts were offered and served while residents were still eating their main course.

Resident interviews revealed resident's feel rushed to finish their meal when desserts are offered and served while they are still eating their entrees.

A review of the home's policy and interview with staff confirmed the expectation that meals are served one course at a time; specifically dessert should be served after the entree is completed and cleared away. [s. 73. (1) 8.]

3. The licensee had not ensured all residents were seated at tables at an appropriate height in the dining room.

Staff confirmed the dining room tables were not at an appropriate height for identified residents when they were seated. [s. 73. (1) 11.]

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 sufficient time is provided for residents to eat at their own pace, that meals are served course by course and that tables are at an appropriate height for residents sitting at the dining room table, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)

(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The Licensee had failed to ensure all required information was posted in a conspicuous and easily accessible location. [s. 79. (1)]

2. Observations made during the inspection revealed the home's policy to promote zero tolerance of abuse and neglect of residents was not posted.

Staff interview with the Director of Nursing (DON) revealed this policy should be posted at the front door or on the bulletin board in the Westminster neighbourhood. [s. 79. (3) (c)]

3. The written procedure for making complaints to the Director was not posted with current information.

The DON was able to show copies of the poster that the home has received but have not been laminated yet - thus not posted. [s. 79. (3) (f)]

4. The home's policy for the minimizing of restraints of residents and the information about how to obtain a copy of the policy were not posted.

The DON revealed this policy should be posted by the front door or on the bulletin board in the Westminster neighbourhood. [s. 79. (3) (g)]

5. The home's evacuation procedures were not posted.

A red binder at each nurses' station included the evacuation procedures however this information was not posted in a conspicuous and easily accessible location.

The Environmental Service Manager revealed the home's evacuation procedure for the public would be to have them leave the home and the staff would give that direction at the time. [s. 79. (3) (j)]

6. The explanation of whistle-blower protections related to retaliation was not posted.

Staff interview with DON revealed the explanation of whistle-blower protections should be posted by the front door or on the bulletin board in the Westminster neighbourhood. [s. 79. (3) (p)]

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 all required information in the Regulations is posted in the home, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee had not sought the advice of the Residents' and Family Councils in developing and carrying out the survey, and in acting on it's results.

This was confirmed by a review of the minutes of the meetings, interviews with members of the Councils and the home's management. [s. 85. (3)]

2. The licensee had not ensured the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey were documented and made available to the Residents' and Family Councils.

This was confirmed by a review of the minutes of the meetings, interviews with members of the Councils and the home's management. [s. 85. (4) (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 advice is sought from the Residents' and Family Councils in developing and carrying out the survey, and in acting on it's results and that actions taken to improve the home are documented and made available to the Councils, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee had not ensured every verbal complaint made to a staff member was investigated.

A resident requested to speak with the Charge Nurse to report an allegation involving a staff person. An investigation was not conducted.

This was confirmed by management of the home. [s. 101. (1) 1.]

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 every written or verbal complaint made to the licensee or staff member concerning the care of a resident is dealt with according to the Regulations, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The Licensee has failed to ensure there is a documented reassessment, at least quarterly, of each resident's drug regime.

Chart reviews revealed some residents in one neighbourhood did not have quarterly reviews completed consistently in the last year.

This was confirmed in interviews with the Director of Nursing and the home's pharmacy. [s. 134. (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 there is a documented reassessment, at least quarterly, of each resident's drug regime, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).
3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The licensee had not ensured all required information was posted in the home.

The Ministry's toll free number for making complaints and the hours of service were not posted.

The Duty To Protect poster was posted but had outdated information (i.e., the name and address of the Director were incorrect).

The Director of Nursing was able to show Inspector #172 the new posters that the home is planning to laminate and determined one could be posted immediately before laminating. [s. 225. (1) 4.]

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 all required information in the Regulations is posted in the home, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The Licensee had failed to ensure staff participated in the infection prevention and control program.

Various personal care items, such as urinals and bedpans were found on the floor in the bathrooms in one neighbourhood. Various unlabeled personal care items such as combs, brushes, recapped disposable razors and deodorant were found in two of the neighbourhoods.

Interview with the Director of Nursing (DON) confirmed personal care items should be labeled for resident's personal use. Deodorant, toothpaste, combs, and brushes should not be found unlabeled. The DON and Assistant Director of Nursing do routine rounds and " sweep and toss" any items found unlabeled in the tub rooms or showers. [s. 229. (4)]

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 staff participate in the infection prevention and control program, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee had not ensured the plan of care was based on an interdisciplinary assessment of pain.

An identified resident's plan of care did not include pain management. The plan of care did not include an assessment and plan for management of pain as it correlated to times of day, activities of daily living, or the environment (i.e., temperature) in order to develop interventions related to prevention.

Staff confirmed pain management was missing from the plan of care and the plan was subsequently updated. [s. 26. (3) 10.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The Licensee had failed to ensure compliance with manufacturer's instruction for storage of drugs.

Emergency drug supply review revealed one expired ampoule of Sodium Chloride 0.9% that expired February 1, 2013. One ampoule of 1% Lidocaine was found open but not labeled with an opened or 30 day expiry date. The Lidocaine was originally dispensed Aug 27, 2012.

The expiration date and unlabeled open ampoule was verified with the RN in the Westminster neighbourhood. [s. 129. (1) (a)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
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. (1)	CO #001	2012_183135_0020	172

Issued on this 5th day of March, 2013

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

Elisa Wilson

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ELISA WILSON (171), CAROLE ALEXANDER (112), JOAN WOODLEY (172)
Inspection No. / No de l'inspection :	2013_186171_0005
Log No. / Registre no:	L-000077-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 4, 2013
Licensee / Titulaire de permis :	~~THE HOMEWOOD CORPORATION~~ Schlegel Villages Inc ~~150 DELHI STREET, GUELPH, ON, N1E-6K9~~ 325 Max Becker Drive, Suite 201, Kitchener, ON
LTC Home / Foyer de SLD :	THE VILLAGE OF GLENDALE CROSSING 3030 Singleton Avenue, LONDON, ON, N6L-0B6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MICHELLE VERMEEREN SCHLEGEL VILLAGES INC

To ~~THE HOMEWOOD CORPORATION~~, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2012_183135_0020, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan to ensure policies required under the Act are implemented and complied with.

The plan must include:

1. Timelines for education of all applicable staff on policies related to Head Injury Routine, Weight and Height Monitoring, Pain Management and Catheter Care.
2. Description of how compliance to policies will be monitored in the home on an on-going basis

Please submit the plan in writing to the London Service Area Office by March 22, 2013.

Grounds / Motifs :

1. Non-compliance with this regulation was issued as an order in December 2012, as a voluntary plan of correction in July 2012, and as a voluntary plan of correction in February 2012.
(172)

2. The Licensee had not ensured that the Pain Management Policy, effective

December 2010, was complied with.

A review of documentation revealed the weekly pain assessment tool was not being used weekly as per policy for an identified resident.

Staff interview with the Director of Nursing revealed the home's expectation was the weekly pain assessment tool would be completed as well as a pain assessment note in the progress notes. Registered staff were also expected to initial in the Medication Administration Record (MAR) that the assessment had been completed as per current policy.
(172)

3. The licensee had not ensured the policy regarding a post-fall head injury routine was complied with.

A review of documentation revealed the Neurological/Head Injury Vitals Signs Record was not always used after unwitnessed falls as per policy. Also a review of progress notes revealed staff were not documenting electronically twice per shift for residents on a head injury routine.

Staff confirmed a head injury routine should be started after unwitnessed falls and that the Neurological/Head Injury Vital Signs Record should be used. (171)

4. The licensee had not ensured that the policy regarding catheter care was complied with.

The Catheter Care Policy (04-24) indicated "catheter output recording should be done every shift, indicating amount, colour and consistency". A review of documentation revealed this was not being completed on a regular basis. (171)

5. The licensee had not ensured the policy regarding weight monitoring was complied with.

The Home's policy indicated weights would be taken and recorded monthly for all residents. However when records were checked on February 6, 2013 the weights for January 2013 were missing for six of the 15 residents reviewed.

Staff confirmed weights were expected to be completed monthly in kilograms

and that the weights for the above residents were missing.
(171)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2013

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 228. Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Order / Ordre :

The licensee will develop and implement a quality improvement program for food services including a written description of the system that includes goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

The licensee must also ensure the names of persons participating in evaluations and the dates improvements were implemented are documented.

Grounds / Motifs :

1. Non-compliance to O.Reg. 79/10, s. 228.1 and 228.4.ii were issued as a voluntary plan of correction in February 2011 regarding the food services department.

Nine out of 23 residents and family (39%) interviewed during this Resident Quality Inspection had concerns about food services, including food quality, taste, temperature and tables being set with dirty dishes. There were also concerns expressed regarding how the meals were served, including staff reaching in front of residents, table cloths being removed while residents were still seated at the table and desserts being served before entrees were finished, making the residents feel rushed.

The Home did not have a written description of the quality management system that included its goals, objectives, policies, procedures and protocols related to food services.

The food services department participated in food committee meetings and completed various audits, however there was no documentation provided to indicate how food services analyzed, evaluated and improved the quality of their services based on the information they collected in audits and meetings.

The Food Service Director confirmed a process was not in place and that there were no surveys or audits completed that would evaluate the resident's satisfaction with the quality and taste of the food offered.
(171)

2. The licensee had not ensured the names of the persons participating in evaluations and the dates improvements were implemented were documented.

The food services department had made some improvements in care and services; however the dates and persons involved in the evaluation were not documented. This was confirmed by the home's management. (171)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2013

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4th day of March, 2013

Signature of Inspector / Signature de l'inspecteur : Elisa Wilson

Name of Inspector / Nom de l'inspecteur : ELISA WILSON

Service Area Office / Bureau régional de services : London Service Area Office