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
Jun 3, 2016	2016_271532_0012	015610-16	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 RIVERSIDE GLEN
60 WOODLAWN ROAD EAST GUELPH ON N1H 8M8

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

NUZHAT UDDIN (532), DOROTHY GINTHER (568)

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): May 20 and 24, 2016

During the course of the inspection, the inspector(s) spoke with the Director of Care, Resident Assessment Instrument (RAI) Coordinator, Neighbourhood Coordinator, Associate Director(s) of Care, Registered Nurse, Registered Practical Nurses, Personal Support Workers , Resident and Family members.
Inspector also toured the resident home areas, observed resident care provision; resident/staff interaction, reviewed relevant resident’s clinical records, relevant policies and procedures, as well as notes pertaining to the inspection.

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

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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on the assessment of the resident and the needs and preferences of that resident.

Record review indicated that an identified resident had approached a staff member and reported an incident.

During an interview the Assistant Director of Care (ADOC) was asked about the plan of care related to toileting. The ADOC responded by stating that the identified resident usually called for assistance and staff assisted the identified resident on the toilet.

A Personal Support Worker (PSW) was interviewed and they reported that when they worked a specified shift they would take the resident to the washroom at a specified hour but sometimes when the identified resident was sleepy they would just check and change the resident.

Power of Attorney (POA) was interviewed and they shared that the identified resident had reported that they were capable of using the toilet if they had help and would prefer that during a specified shift and at a specified hour.

Review of the plan of care revealed that the identified resident's preference for the specified shift was not indicated in the plan of care and no mention regarding the check and change program.

Interviewed with the Neighbourhood Coordinator indicated that the expectation was for the plan of care to be based on the resident's needs and preferences and the staff were expected to provide care based on those needs.

The scope of this issue was isolated to this one resident. There was compliance history related to the plan of care. The severity was determined to be a level one as the plan of care should be based on the resident's needs and preferences and it was not. [s. 6. (2)]

Issued on this 6th day of June, 2016

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

Original report signed by the inspector.