



**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 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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Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 3, 2017	2017_609569_0003	000075-17, 000139-17	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

DONNA TIERNEY (569)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 30 and 31, 2017, February 1, 2, and 6, 2017.

This following intakes were completed during this complaint inspection:

Log #000075-17 - Critical Incident #2979-000001-17 related to potential resident to resident abuse

Log #000139-17 - IL #48674-LO Complaint related to potential resident to resident abuse and multiple resident care issues.

Inspector #680 also participated in part in this inspection.

During the course of the inspection, the inspector(s) spoke with the General Manager, Director of Care, Assistant Director of Care, a Physician, a Registered Nurse, five Registered Practical Nurses, a Registered Dietitian, a Neighbourhood Co-ordinator, four Personal Support Workers (PSW), two family members, and three residents.

The inspector(s) also conducted a tour of relevant home areas, and made observations of residents, staff to resident and resident to resident interactions as well as activities and care provided to residents. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:

**Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care**

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

2 WN(s)

2 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :



1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

An identified resident suffered an incident on a specified date that required them to have a specific intervention as a result.

Clinical records indicated that the identified resident was assessed by the attending Nurse Practitioner (NP). The NP ordered a specific test to be completed. The order was signed by the NP as well as two other registered staff. On the order it indicated that a specific form was filled out and signed by one of the registered staff as well as stamped as faxed.

Interviews were conducted with the Director of Care (DOC) and three registered staff related to the processing of specific orders. The DOC said that two nurses would process an order and both are responsible to make sure it is completed and then both sign the order as such. They are also responsible to make sure the home's specified form is filled out as part of the process. Then the completed order is delivered to a specified area where the registered staff faxes them.

The three registered staff shared similar information related to the processing of specific orders. When asked what the process is to ensure that orders are processed and completed the three registered staff said they didn't know. One of the registered staff acknowledged that the specific order for the identified resident for a specified date was not completed.

The DOC also said during an interview that the whereabouts of the specific order for the identified resident for a specified date was unknown and therefore not completed.

The licensee failed to ensure that the specific order for the identified resident ordered on a specified date was provided to the resident as specified in the plan.

The severity of this issue is determined to be a level 2 which is minimal harm/risk or potential for actual harm and the scope a level 1 which is isolated. The home has a compliance history of similar non-compliance in this area of legislation. [s. 6. (7)]



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 the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

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 :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

An identified resident was involved in a specific incident that required them to be transferred to hospital for treatment. They then returned back to the home on a specified date.



A "Skin Assessment – Re-Admission" document was found in the resident's clinical record upon return from the hospital. The form identified specific areas of altered skin integrity.

Review of the resident's clinical record showed a "SKIN ASSESSMENT CONCERNS" form and "WOUND ASSESSMENT TOOL" located in the Treatment Administration Record (TAR) binder. The forms were not completed.

An interview was conducted with the Assistant Director of Care (ADOC) /wound care lead. They explained that the process for all residents returning from hospital is that they are to receive a head to toe assessment within 24 hours and a skin assessment concern form is completed for any skin integrity issues identified and then forwarded to the ADOC. Additionally the home's 'Wound Assessment Tool' is used for every skin issue including a bruise and a surgical wound.

The ADOC said that they had not received a skin assessment concern form for the identified resident and said that a skin assessment was not completed for the resident's skin integrity issues upon return from the hospital.

The licensee failed to ensure that the identified resident received a skin assessment by a member of the registered nursing staff for their altered skin integrity issues using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The severity of this issue is determined to be a level 2 which is minimal harm/risk or potential for actual harm and the scope a level 1 which is isolated. The home has a compliance history of similar non-compliance in this area of legislation. [s. 50. (2) (b) (i)]



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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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.

Issued on this 10th day of May, 2017

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

Original report signed by the inspector.