Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**London District**
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

# Original Public Report

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| **Report Issue Date:** November 26, 2024 |
| **Inspection Number:** 2024-1461-0006 |
| **Inspection Type:**<br>Complaint<br>Critical Incident |
| **Licensee:** Schlegel Villages Inc. |
| **Long Term Care Home and City:** The Village of Glendale Crossing, London |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 18, 19, 2024

The following intake(s) were inspected:

- Intake: #00127315 was a complaint regarding the fall prevention and management
- Intake: #00128778/CI #2979-000067-24 related to medication administration requiring a hospital transfer.
- Intake: #00129295 related to fall prevention and management.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

## INSPECTION RESULTS

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## WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (5)**
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that the Substitute Decision Maker (SDM) was provided an opportunity to fully participate in the development and implementation of the resident's plan of care related to the use of an assistive device.

**Rationale and Summary:**

A review of progress notes revealed that the resident had been using an assistive device for several years. A progress note indicated that the assistive device was replaced with a different assistive device due to safety concerns.

The clinical records indicated that the SDM was not notified of the change in the resident's plan of care.

A Kinesiologist confirmed that the SDM should have been notified of the change to the resident's plan of care. However, no such notification occurred. The Associate Director of Care (ADOC)/Falls Lead also confirmed that the change in the resident's assistive device should have been communicated to the SDM.

The failure to notify the SDM about the assistive device change prevented their involvement in the development of the resident's care plan, which led to inadequate

fall prevention strategies. This increased the risk of falls and fall-related injuries.

Sources: Clinical records, interviews with staff, Kinesiologist, Falls Lead/ADOC.

## WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 29 (3) 18.**
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions.

The licensee failed to ensure that the plan of care for the resident was based on an interdisciplinary assessment of the resident's needs and risks prior to the change in their assistive device.

**Rationale and Summary:**

A review of the clinical records revealed that the resident had been using an assistive device for several years. A progress note documented the replacement of the assistive device due to safety concerns.

An Occupational Therapist (OT) confirmed that an assessment should have been conducted before the assistive device change to evaluate the resident's needs, mobility, comfort, and risk factors. These assessments should have been documented in the resident's clinical records.

A Kinesiologist explained that typically, OT would conduct the assessment, followed by a Resident Assessment Instrument (RAI) team review for Personal Assistance Service Devices (PASDs), notification of the Power of Attorney (POA), and updates to the care plan before introducing a new assistive device. The vendor would also be informed of an assistive device's measurements and suitability.

However, there was no documentation in the resident's clinical records indicating that an interdisciplinary assessment had been conducted before the trial of the assistive device.

This failure resulted in the omission of a thorough, interdisciplinary evaluation of the resident's needs and risks. Not conducting the necessary assessment placed the resident at risk for falls and fall-related injuries.

Sources: Resident clinical records, interviews with RN, OT, and Kinesiologist.

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