Ontario

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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 31, 2019	2019_545147_0006	025420-18, 001208-19, 009616-19, 012085-19	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 Riverside Glen
60 Woodlawn Road East GUELPH ON N1H 8M8

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

LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 28, July 2, 3, 4, 5 and 8, 2019

The following intakes were inspected:

Log #025420-18 - Critical Incident System (CIS) related to unknown fracture
Log #001208-19 - CIS related to allegations of staff to resident abuse
Log # 009616-19 - CIS related to allegations of staff to resident abuse and
Log # 012085-19 - Complaint related to allegations of abuse and neglect of care

During the course of the inspection, the inspector(s) spoke with with the Assistance General Manager, Director of Care (DOC), Kinesiologist, Neighbourhood coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Assistant (PCA), Dietary Aide and residents.

During the course of this inspection, the inspector observed resident care,observed staff to resident interaction, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	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. (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).

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 :

1. The licensee failed to ensure that there was a written plan of care for resident #001 that sets out, clear direction to staff and other's who provide direct care to the resident.

In May 2019 during snack service, resident #001 was being served a hot beverage by PCA #108. Review of the home's incident report identified that there was an accident with the beverage which caused an injury to the resident.

During an interview with PCA #108 they acknowledged that during snack service they served a hot beverage to resident #001. The PCA stated that they were not aware of the resident's current plan of care and were not aware that the resident had a specified impairment. The PCA recalled the incident and the resultant injury to the resident. They said they notified registered staff right away following the incident.

Review of the resident's clinical records showed that the resident required daily treatment for their injury.

The care plan for resident #001 did not include clear direction to staff and others who provide direct care to resident #001 related to interventions surrounding safety and their specified impairment.

During an interview with DOC #100 they shared that it was their expectation that resident #001's care plan be updated with the resident's current care needs so that it would provide clear direction to staff and others who provide direct care to the resident.

The licensee failed to ensure that the plan of care for resident #001 sets out, clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that when the resident was being reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Review of resident #001's progress notes and post fall incident form showed that resident #001 had a fall in June . The post fall incident form was completed and the resident was assessed by RPN #102 at the time of the fall and documented the resident complained of aches and pains.

Staff #103 acknowledged that the resident has had numerous falls, and interventions had been put in place to reduce the risk of falls. They stated that since the resident's fall in February 2019, the home had implemented different falls prevention strategies.. Staff #103 also stated that the resident's mobility had changed since their falls. They now required a a specified aid for mobility and one person assist to transfer.

Review of resident #001's care plan under the Mobility sections identified that they used specified devices for mobility. Under Transferring it identified a specific level of assistance.

Multiple observations were made of resident #001 during the inspection period which showed the resident no longer used the specified device for mobility.

PSW #104, Staff #103 and #105 shared that since resident #001 fell in June 2019, their mobility aids had changed and their level of mobility and transfers had declined.

The licensee failed to ensure that the plan of care for resident #001 was reviewed and revised when the resident's care needs changed after resident #001 fell on June 15, 2019. [s. 6. (10) (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 that every licensee of a long term care home shall ensure that there is a written plan of care for each resident sets out, clear direction to staff and others who provide direct care to the resident and that when the resident was being reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint received by the Ministry of Long Term Care (MOLTC) by resident #001's Substitute Decision Maker (SDM) stated that on numerous visits they had noticed that the resident had not received personal hygiene as needed.

During interviews with RPN #102, PCA #104, DOC #100 and staff #105, it was difficult to provide the resident with the bathing method of their choice. As a result, the staff were providing an alternative bathing method on a regular basis.

Review of resident #001's plan of care identified that the resident preferred a specific method of bathing. Point of Care (POC) documentation for the months of April, May and June 2019 showed that the resident did not receive their bath preference but there was no documentation to support the reason.

Further review of POC documentation also indicated that resident #001 did not receive their bath preference between April to June 2019. The documentation showed that during the three-month period, resident #001 did not get bathed by their method of choice 26/26 (100 per cent) times.

The home failed to ensure resident #001 was bathed at a minimum, twice a week by the method of their choice. [s. 33. (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 that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every licensee of a long term care home shall ensure that each resident of the home received preventive and basic foot care services, including the cutting of toenails, to ensure comfort, and prevent infection and that they received fingernail care, including the cutting of fingernails.

A complaint received by the Ministry of Long Term Care (MOLTC) from resident #001's Substitute Decision Maker (SDM) stated that on numerous visits they had noticed that the resident had not received personal hygiene as needed.

Review of the resident's clinical records for the months of April, May, June and July 2019 showed that the resident had not received their scheduled twice bathing. As a result the nail and basic foot care that occurred in conjunction with the bathing had not been done.

Interview with RPN #102, PCA #104 and DOC #100 acknowledged that it was the expectation of the staff to ensure that nail and basic foot care was provided on bath days for residents. However, since resident #001 had not had their baths twice weekly, this task did not always occur. RPN #102 and PCA #104 both stated that they provided an alternative bathing method to resident #001 on a regular basis, however, nail and basic foot care was not part of this routine.

DOC #100, RPN #104 and staff #105 stated that the resident had a specialist visit the resident in April 2019, however, they were unable to provide foot care for resident #001. Review of the progress notes and further interviews with DOC #100 and RPN #104 stated there had been no further follow up to address the resident's foot care needs since then.

The home failed to ensure that resident #001 received preventive and basic foot care services, including the cutting of nails, to ensure comfort, and prevent infection and that they received fingernail care, including cutting of fingernails. [s. 35. (1)]

Issued on this 1st day of August, 2019

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

Original report signed by the inspector.