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
Sep 17, 2019	2019_750539_0013	002522-19	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

VALERIE GOLDRUP (539), TAWNIE URBANSKI (754)

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): August, 1, 6-9, 12-16, 19-22, 2019.

The following intakes were completed in this Complaint inspection:

Log #002522-19/ IL-63857-CW, a complaint regarding resident care.

This inspection was completed concurrently with Complaint inspection 2019_750539_0014 and Complaint inspection 2019_750539_0015.

During the course of the inspection the inspector(s) toured the home and observed resident care, services and activities. Clinical records and plans of care for identified residents were reviewed. Also, relevant documents were reviewed including but not limited to the home's documentation and procedures as related to the inspection.

During the course of the inspection, the inspector(s) spoke with the General Manager, Assistant General Manager, Director of Nursing Care (DOC), Assistant Directors of Care (ADOC), a Personal Expression Resource Team member (PERT), A Resident Assessment Instrument (RAI) Coordinator, a Social Service Coordinator, a Dietitian, a Kinesiologist, Neighbourhood Coordinators, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Assistants (PCA), residents and their families.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
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	
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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Resident #001's altered skin integrity, documented since June 2017, worsened from January to March 2018.

A) The staff did not collaborate regarding resident #001's declining nutritional intake.

Resident #001 lost weight between June and December 2017 and in December 2017 was taking a very long time to eat their meals.

The Food and Nutrition Manager did not initially refer to the Registered Dietitian (RD) so that resident #001 could be followed as high risk when they met the criteria in December 2017.

B) The staff did not collaborate regarding resident #001's declining mood.

From June 2017 resident #001's mood declined and in December 2017 the resident was spending a lot of time in their room, and refusing more and more programs.

No additional assessments of the resident in relation to their mood were completed during this time period. The DOC stated it was the staff's professional judgement when to do additional assessments for mood to determine the impact on the resident.

C) The staff did not collaborate with the physician regarding resident #001's worsening altered skin integrity.

Record review documented the physician did not participate in the assessment of the resident's altered skin integrity until January 2018, at which point the altered skin integrity was very advanced.

D) The staff did not collaborate with the Registered Dietitian (RD) regarding the treatment of resident #001's worsening altered skin integrity.

A Dietitian Referral for the specified altered skin integrity was completed by the RD in February 2018 at which point the skin concern was advanced. Resident #001 had documented altered skin integrity in the previous months that should have been assessed by the RD.

E) Staff did not collaborate with the Physiotherapist, Kinesiologist, and Occupational Therapist (OT) regarding resident #001's worsening altered skin integrity.

Resident #001's Physiotherapy Assessments, in December 2017 and March 2018 were incomplete and there was no collaboration with other team members.

The Kinesiologist reviewed resident #001 in January 2018. The Kinesiologist and the OT received a referral to review resident's #001's needs in March 2018 at which point the resident's altered skin integrity had worsened.

Resident #001 was not assessed for treatments and devices to prevent skin breakdown until the resident's altered skin integrity worsened.

F) The staff did not collaborate with the Skin and Wound Care Consultant in the treatment of resident #001's worsening altered skin integrity.

An assessment by the home's Skin and Wound Care Consultant did not occur until March 2018.

The ADOC confirmed that there was no previous specialized assessment completed by the Skin and Wound Care Consultant for resident #001.

The licensee failed to ensure staff and others involved in the different aspects of care for resident #001 collaborated with each other in the prevention and treatment of the resident's worsening altered skin integrity, to ensure their assessments were integrated, consistent with and complemented each other.

2. The licensee failed to ensure that resident #001's substitute decision-makers were given an opportunity to participate fully in the development and implementation of resident #001's plan of care.

Resident #001 was described as a resident that could be independent with some decisions, but due to cognitive decline, may require assistance to make appropriate decisions at times.

Staff stated the expectation of the home was that they contacted the family of incapable residents. They stated that they would document in Point Click Care (PCC) under POA communication when notifying families of a resident's change in condition; sign the physician's orders when an order was written to notify the family; and document in the skin and wound referrals their contact with families.

Registered staff reviewed the documentation for resident #001 and stated that the family was advised of resident #001's altered skin integrity in December 2017, and there had been family meetings in March 2018. They could not locate documentation that the family had been notified of the resident's worsening altered skin integrity.

The licensee failed to ensure that resident #001's substitute decision-makers were given an opportunity to participate fully in the development and implementation of the resident's plan of care for the worsening altered skin integrity.

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;

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, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 and resident #005 had a nutrition assessment when there was a significant change in a resident's health condition and that the resident's hydration status was assessed.

Documentation review for resident #001 showed that the resident did not meet their fluid requirements for three consecutive days during two specified periods in April 2018.

The Home's Policy stated that residents who did not meet their fluid requirements would be assessed by the Registered Staff for signs and symptoms of dehydration via the Dehydration Risk Screener. If a resident exhibited one or more signs and symptoms of dehydration, a Dietitian Referral was required to reassess the resident's hydration needs.

Registered Staff stated that the Dehydration Risk Screener tool was initiated for resident #001 on the two occasions in April 2018 when they showed one or more signs and symptoms of dehydration. They stated that the expectation would then be to complete a Dietitian referral for a dehydration risk assessment. There was no Dietitian referral found for dehydration or an assessment of hydration status in April 2018 for resident #001.

2. Documentation review for resident #005 showed the resident did not meet their fluid requirements for three consecutive days in July 2019.

Registered staff stated that the Dehydration Risk Screener, initiated in July 2019 showed one or more signs and symptoms of dehydration and required a Dietitian referral. They confirmed that they did not see a Dietitian referral or assessment for dehydration risk completed in July 2019 for resident #005.

The licensee has failed to ensure that resident #001 and resident #005 had a nutrition assessment when there was a significant change in a resident's health condition and their hydration was assessed.

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 registered dietitian who is a member of the staff of the home, (a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and (b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3), to be implemented voluntarily.

Issued on this 3rd day of October, 2019

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

Original report signed by the inspector.