Ontario

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 # / No de registre	Type of Inspection / Genre d'inspection
May 2, 2018	2018_420643_0005	006326-18	Follow up

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 Erin Meadows
2930 Erin Centre Boulevard MISSISSAUGA ON L5M 7M4

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

ADAM DICKEY (643)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 28, and April 2-6, 2018

The following compliance order follow-up was inspected:
Log #006326-18 related to safe transferring techniques.

Inspector Praveena Sittampalam #699 attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Acting Director of Nursing Care (DON), Assistant Director of Nursing (DON), Kinesiologist (KIN), Registered Practical Nurses (RPN), RAI-MDS Coordinator (RMC) and Personal Support Workers.

During the course of the inspection, the inspector(s) conducted observations of residents and the provision of care, record review of resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2018_631210_0005	643

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. (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. (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 failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

As a result of identified noncompliance for resident #001, the sample of residents was expanded to include resident #002 for inspection of plan of care related to transferring and positioning techniques.

Review of resident #002's health records revealed they had identified medical diagnoses and health conditions. Review of resident #002's Minimum Data Set (MDS) assessment revealed they required extensive assistance from two persons for transferring and were lifted mechanically.

Review of resident #002's current plan of care revealed they required extensive assistance of two staff members for transferring. A transfer logo located above resident #002's bed showed two person physical assistance and additionally indicated staff were not to use a specified type of transfer equipment which was added onto the logo with a printed label.

In an interview, PSW #121 stated that there was a logo located in the resident room with transfer method indicated. PSW #121 additionally stated that the above mentioned specified transferring equipment had been tried with resident #002 but was not effective. PSW #121 stated they had discussed resident #002 with the Kinesiologist (KIN) who told the PSW resident #002 should not use the specified transfer equipment.

In an interview, RPN #114 stated resident #002 is transferred using an identified method, and if resident #002 was unable to transfer using this method staff would be able to use the above mentioned specified transfer equipment to transfer the resident. RPN #114 indicated the resident would need to be able to follow instructions and weight bear to use that type of equipment. RPN #114 was unaware of the logo in the room indicating that resident #002 was not to be transferred using the specified transfer equipment. RPN #114 stated that as the written plan of care and the transfer logo did not give the same direction to staff there were not clear directions to staff related to transferring.

In an interview, KIN #103 stated that assessment of a resident transfer status was completed by the KIN or Physiotherapist (PT) who would update the resident care plan and place the correct transfer logo at the bedside. KIN #103 stated they assess residents on the most minimal transfer method required and the team members would make a judgement call to use a lift if the resident required. KIN #103 indicated it would be the PSW who would be expected to make the judgement on the spot as they are the ones providing direct care.

Review of Kinesiology transfer assessment conducted March 18, 2018, revealed resident #002 had been assessed for an identified type of manual assistance transfer and no indication was given if the resident was safe to use the above mentioned specified transfer equipment.

In an interview Assistant Director of Nursing (ADON) #120 stated a resident would require upper trunk strength, be able to weight bear and follow instructions to the specified transfer equipment. ADON #120 indicated that it was the practice in the home that if a resident was not able to transfer by the care planned method staff could use the next level up. ADON #120 stated that expectation of the home was for the written plan of care for transferring to always match the transfer logo indicated in the resident room. ADON #120 acknowledged that the difference in transfer logo and written plan of care for resident #002 did not give clear direction to staff related to transferring. [s. 6. (1) (c)]

2. The licensee has failed to ensure the care set out in the plan of care was based on an assessment of the resident.

This inspection was initiated related to follow-up inspection to compliance order CO#001 under inspection report 2018_631210_0005. The licensee was ordered to be in compliance with O. Reg. 79/10, r. 36. by March 26, 2018, to ensure staff used safe

transferring and positioning techniques when assisting resident #001.

Review of resident #001's health records revealed they were admitted to the home with identified medical diagnoses. Review of resident #001's current plan of care accessed revealed they required extensive assistance from two staff for transferring. The plan of care had been updated on an identified date to include instruction to staff to assess the resident in the moment if unable to transfer safely with two person assistance. Staff were instructed to assess the resident ability to follow instructions, partially weight bear, hold on to the transfer equipment, keep body upright and be reliable and cooperative for use of a specified type of transfer equipment. The plan further instructed that if unable to transfer with the specified transfer equipment, staff were to use a specified mechanical lift and to notify team leader.

In an interview, KIN #103 stated that assessment of a resident transfer status was completed by the KIN or PT. When asked if resident #001 was assessed for the use of the above mentioned transfer equipment. KIN #103 stated they assess on the most minimal transfer method required and the team members would make a judgement call to use a piece of equipment if the resident required. KIN #103 indicated it would be the PSW who would be expected to make the judgement on the spot as they are the ones providing direct care.

Review of Kinesiology transfer assessment conducted on an identified date three months prior, revealed resident #001's transfer status was two person assist and was able to transfer with verbal cues and encouragement. The assessment did not indicate a response if resident #001 was safe to use the specified transfer equipment.

In an interview, RMC #105 stated there was no information specified in the KIN assessment regarding resident #001's ability to use the above mentioned specified transfer equipment. RMC #105 stated there had not been a referral to KIN to reassess resident #001 for the use of the specified transfer equipment.

Review of resident #001's health records failed to reveal an assessment of the resident's transfer status in relation to the safe use of the specified transfer equipment and their ability to follow directions while using the specified transfer equipment. No assessment was conducted as the basis of the changes to resident #001's plan of care on on the above mentioned identified date.

In an interview, ADON #120 stated assessments are done by the KIN or PT and PSW

staff are taught to use best judgement to transfer a resident safely. ADON #120 stated if a resident was not able to transfer with two person transfer staff were able to use the above mentioned transfer equipment, and if unable to follow instruction or weight bear and use upper trunk control to use a hoyer lift. ADON #120 acknowledged that an assessment had not been completed by KIN or PT to reflect the changes made to the care plan, and had failed to base the planned care on an assessment of the resident. [s. 6. (2)]

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 based on an assessment of the resident; and
- that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 2nd day of May, 2018

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

Original report signed by the inspector.