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 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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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 3, 2019 | 2018_526645_0017 | 009590-18, 022140-18 | 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 Erin Meadows
2930 Erin Centre Boulevard MISSISSAUGA ON L5M 7M4

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

DEREGE GEDA (645), IVY LAM (646)

## 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): November 26, 27, 28, 29, 30, December 3, 4 and 5, 2018.**

**During the course of the inspection, the following complaint intake logs were inspected: Log #009590-18 and #022140-18.**

**A Voluntary Plan of Action related to LTCHA,2007, c.8, s. 36, identified in a concurrent critical incident inspection #2881-000017-18 (Log #018440-18) was issued in this report.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, General Manager, Assistant Director of Nursing Care (ADNC), Neighborhood Care Coordinator (NCC), Physiotherapist (PT), Kinsiologist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, and Family Members.**

**The inspectors conducted observations of medication administration, dining services, staff to resident interactions, provision of care, record review of residents' and home records, staff training records, staffing schedules, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Nutrition and Hydration**
**Personal Support Services**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The Licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents with transfers.

A complaint was received via the MOHLTC INFO-LINE (IL) regarding resident #001. During the interview, the complainant alleged that they have a video footage of two staff members being inappropriate when providing care to resident #001. Inspector #645 reviewed the video surveillance footage together with the complainant.

On an identified date, Inspector #645 reviewed the video footage with Kinisiologist #109. After reviewing the video, the Kinisiologist confirmed that the two PSWs did not use proper techniques when providing care to resident #001. The Kinisiologist indicated that the two PSWs provided unsafe care and reiterated that they will retrain them again.

Interview with the General Manager confirmed that the two PSWs commenced unsafe and inappropriate care. They stated that they will counsel both staff members and provide retraining.[s. 36.]

2. This inspection was initiated to inspect on Critical Incident Report (CIR) submitted to the MOHLTC, related to an incident that caused an injury to resident #012 requiring hospitalization.

Review of the resident #012's written plan of care indicated the resident needed to use an identified transferring equipment and techniques with the help of two team members.

Review of the home's progress notes showed that RPN #107 was called to assess resident #012's injury during morning care. Upon assessment, RPN #107 indicated the resident had pain when the RPN touched the identified part of the resident's body, and the NP was called to assess the resident.

Review of the home's investigation notes identified that PSW #118 was assigned to resident #012 that day, and had identified that the resident had pain that morning, and transferred the resident with PSW #116 using the identified transferring equipment, and PSW #116 asked PSW #118 to get the RPN to assess. When the NP came to assess, PSW #118 and PSW #101 transferred the resident back to bed with a different transferring equipment than the identified equipment mentioned above.

During the interview, PSW #118 stated they were assigned to resident #012 on that day, but resident #012 was not their regular assigned resident. They confirmed that they conducted unsafe transfer using inappropriate transferring equipment when the NP requested to have the resident back to bed for assessment. PSW #101 did not recall the

transfer and unable to give further information.

Interviews with ADNC #111 and the General Manager stated that the staff did not use safe transferring techniques for resident #012 during the transfer on the identified date.

***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 staff use safe transferring and positioning techniques when assisting residents with transfers, to be implemented voluntarily.***

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**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. (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. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's special treatments and interventions.

A complaint was received via the MOHLTC IL, regarding resident #001. The complainant stated that the staff members at the home do not provide incontinence care for the resident regularly.

During the interview, the complainant stated that they have addressed this concern with the management team at the home on an identified date.

Record review of the meeting minutes on the date, indicated that the home held an interdisciplinary team care conference that included the home's management team, front line staff and the complainant. The records indicated that the interdisciplinary team developed a special intervention tool to track the resident's incontinence frequency and care. A review of the plan of care did not indicate if the toileting schedule was included in the plan of care.

On an identified date, Inspector observed the tracking sheet posted at the back of the resident bed. PSW #112 was observed filling out the tracking sheet for the shift. The tracking sheet was filled with staff initials to show the time and frequency of incontinence care.

Interview with PSWs #112 indicated that the staff are filling out the form to track the resident's incontinence frequency. During the interview, PSW indicated that the intervention was not included in the plan of care but a verbal direction was given from the management team to consistently document and track the time of care.

Interview with the NC #115 indicated that resident #001 has Individualized plan of care for incontinence care. They stated that staff members are to document the time on the tracking tool. They confirmed that the tracking tool was not included in the plan of care and reiterated that they would include it in the plan of care as soon as possible. [s. 26. (3) 18.]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (2) The licensee shall ensure that,**
**(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure residents who require assistance with eating or drinking are not served a meal until someone was available to provide the assistance required by the resident.

During lunch meal services on two identified dates (day #1 and day #2), resident #001 was served soup as a starter followed by main course and a desert. On both occasions, the resident was served their meals course by course but there were no staff member assisting with feeding. The soup and the main course was on the table for approximately 45 minutes before the desert was served. Both the soup and the main course were placed on the tables in front of the resident prior to assistance being available.

On both days, meal service commenced at 1200 hours and resident #001's food sat in front of them until they were assisted at 1245 hours on day #1, and 1250 hours on day #2. [s. 73. (2) (b)]

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**Issued on this 3rd day of January, 2019**

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

**Original report signed by the inspector.**