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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Nov 27, 2019	2019_659189_0018	012818-19, 013608-19, 014341-19, 019472-19	Critical Incident System

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

NICOLE RANGER (189), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 13, 14, 15, 18, 2019.

During the course of the inspection, the following Critical Incident System (CIS) intake logs were inspected:
Log #012818-19, #014341-19 related to falls prevention,
Log #019472-19 related to transferring and positioning,
Log #013608-19 Follow up to Order related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Director of Nursing Care (DNC), Director of Environmental Services, Assistant Director of Nursing Care (ADNC), Kinesiologist, Occupational Therapist (OT), Physiotherapist (PT), Food Service Supervisor (FSS), Neighborhood Coordinator (NC), RAI MDS coordinator, Behavioural Support Ontario Lead (BSOL), Behavioural Support Ontario personal support worker (BSO PSW), registered nurse (RN), registered practical nurse (RPN), personal support worker (PSW), agency personal support worker, and residents.

During the course of the inspection the inspectors observed staff to resident interactions, the provision of care, reviewed residents' health records, staff training records, home's investigation notes, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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)**

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
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #001	2019_659189_0006	189

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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 complement each other.

The home submitted a Critical Incident System (CIS) report related to an injury incurred by resident #003 during a transfer.

A review of the written plan of care indicated the resident required extensive assistance of two team members, using a mobility device for toileting. A review of the Occupational Therapist (OT) assessment notes on an identified date, confirmed this identified assistance requirement.

Interview with PSW #113 indicated that on an identified date, they with a second PSW was assisting resident #003 with toileting using a mobility device. They removed the mobility device from the toilet in order to transport the resident to their bed. In the course of completing the care, the device brakes were released and the mobility device tipped forward, propelling the resident forward, they landed on their feet and sustained an injury.

Following this incident RPN #124 sent a referral to the program for active living (PAL) services, requesting for the device to be assessed. The safety assessment of this device falls under the role of the OT. Interview with the OT confirmed that they had not assessed resident #003's mobility device for safety prior to this incident.

Interviews conducted with the OT, Kinesiologist and Physiotherapist (PT) revealed some confusion with whose role this equipment assessment falls under. Interview with RAI MDS coordinator indicated that the referral should have been reviewed by all PAL team members.

Interviews with RPN #124, PT, OT and the Kinesiologist confirmed receipt of the referral, and that the assessment was not completed as per the homes policy.

The home has failed to ensure that the team members collaborated with each other in the assessment of resident #003's mobility device. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care related to fall prevention was provided to residents #002, #007, #009 and #010 as specified in the plan.

The home submitted Critical Incident System (CIS) report to the Ministry of Long Term Care (MLTC) related to a fall with injury for resident #002.

A review of resident #002's written care plan indicated that the resident was at risk for falls and required an identified fall prevention intervention. The staff should attend to the resident when the fall prevention intervention is activated.

A review of the home's policy entitled "Fall Prevention and Management program LTC", undated, indicated that the Neighbourhood Team will follow the strategies as outlined in the plan of care for fall prevention interventions.

On two identified dates, the inspector observed resident #002's identified fall prevention strategy was not in use. Interviews with PSW #122 and RPN #102 confirmed that the equipment was not in use at the time of the observation because it was broken.

Interviews with the Director of Nursing Care (DNC) and the General Manager (GM) confirmed that where the resident's plan of care identified fall prevention strategies, they must be implemented; and they confirmed that they had failed to implement the identified intervention for resident #002. [s. 6. (7)]

3. During the inspection period, the inspector identified areas of non compliance related to a fall prevention intervention not provided to resident #002.

An expanded resident sample inspection was initiated. The inspector conducted an observation on an identified unit with RPN #102 to review all residents' who currently use an identified fall prevention intervention. During the observation, the inspector found the following:

a) Resident #007's call bell and fall prevention intervention were found to be disengaged and out of reach of the resident.

b) Resident #009's call bell and fall prevention intervention was found to be disengaged and out of reach of the resident

c) Resident #010's fall prevention intervention was found to be inaccessible to the resident.

A review of the written plans of care for resident #007, #009, and resident #010 revealed that the residents were at risk for falls and identified the required fall prevention interventions.

Interviews with the DNC and the GM, confirmed that when a resident's plan of care identifies interventions they are to be fully implemented, and they confirmed that for residents #007, #009 and #010, the fall prevention interventions had not been implemented as required. [s. 6. (7)]

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; and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication response system can be easily seen, accessed, and used by residents, staff and visitors at all times.

On an identified date, the inspector conducted an observation of an identified unit with RPN #102. During the observation, the inspector found the following:

1. Resident #007's call bell was found to be disengaged and out of reach of the resident.

2. Resident #009's call bell was found to be disengaged and out of reach of the resident.

A review of resident #007's and resident #009's written plan of care revealed that the call bell cord should be within reach for each resident. A review of the falls risk assessment indicates that resident #007 and resident #009 were at risk for falls.

Interview and observation by RPN #102 confirmed that the call bells were not accessible to the residents. RPN #102 also confirmed that both residents were at risk for falls.

Interview and observation with the DNC and the GM revealed that the home's expectation is that the resident's call bells must be within reach, accessible and on at all times. [s. 17. (1) (a)]

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 home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, and is on at all times, to be implemented voluntarily.

Issued on this 9th day of December, 2019

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

Original report signed by the inspector.