Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2019	2019_549107_0016	019632-19	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 Tansley Woods
4100 Upper Middle Road BURLINGTON ON L7M 4W8

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

MICHELLE WARRENER (107)

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, December 4, 5, 6, 9, 12, 2019

The following intakes were completed during this Complaint Inspection:
Log #019632-19 IL-71024-HA related to resident care and financial concerns

PLEASE NOTE: A written notification related to O.Reg. 79/10, s. 30 (2), and a written notification and voluntary plan of correction related to LTCHA, 2007, S.O. 2007, c.8, s. 6 (4)(b) were identified in this inspection and have been issued in Inspection Report 2019_549107_0015 / 017125-19, 017126-19, dated December 20, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with The Acting Assistant General Manager, Director of Nursing Care, Assistant Director of Nursing Care, Registered and front line nursing staff (RN, RPN, PSW), Registered Dietitian, Nutrition Manager, Administrative Assistant, and Resident Billing Supervisor.

The Inspector reviewed clinical health records, financial documents, complaint records, the licensee's policies and procedures, and investigative notes made by staff and other documents maintained by the home.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Resident Charges

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. (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 failed to ensure that there was a written plan of care for resident #003 that set out the planned care for the resident, the goals the care was intended to achieve, and clear direction to staff and others who provided direct care to the resident, related to a specific medical diagnosis.

A. Resident #003 had a history of a medical condition. Documentation in the resident's progress notes reflected the resident had a significant change in condition and presented symptoms similar to those in their history. Five days after the onset of symptoms, the resident was assessed by the Nurse Practitioner and later was diagnosed with the same medical condition.

During interview with the Director of Nursing Care (DNC) #101, they stated that a history of the recurrent or significant medical condition would be something that should be included in the care plan (CP) for communicating the risk to all staff. The DNC indicated the care plan would identify some signs and symptoms to look for and actions to take.

Prior to the most recent change in condition, the resident's written plan of care included mention of the medical condition in various sections of the care plan, however, did not identify the significant history of the condition, signs and symptoms to watch for, and actions to take if the condition was suspected. The resident was not always able to communicate clearly with staff.

The resident's written plan of care did not clearly communicate the risk of recurrent and significant history of a medical condition, symptoms to assist in the identification of the

condition, and action to take if the condition was suspected.

B. The written plan of care for resident #003 did not provide clear direction to staff providing care to the resident in relation to their required diet texture.

The Registered Dietitian #108 wrote an order to change the resident's diet texture. The diet change was added to the resident's written plan of care under a focus of "Diet Orders".

Not all sections of the resident's written plan of care were revised to include the new diet texture order. Three other sections of the resident's care plan were not revised and still identified the previous diet texture.

During interview with Inspector #107, the Director of Nursing Care (DNC) #101 confirmed that the plan of care did not provide clear direction to staff providing care in relation to the resident's required diet texture. [s. 6. (1)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

A. Resident #003 had a medical directive in place for providing a medication to treat a specific condition. The medical directive identified that staff were to contact the physician if the condition persisted more than 24 hours.

Progress notes, written by the Nurse Practitioner (NP), stated that the resident had the condition for almost three days prior to when the Nurse Practitioner assessed the resident. Documentation on the resident's Medication Administration Record (MAR) reflected the resident was provided with medication to treat the condition for more than 24 hours and the Physician or Nurse Practitioner were not notified as per the medical directive.

During interview with Inspector #107, the Director of Nursing Care (DNC) #101 stated that when resident #003 had the change in condition, the NP was not available to assess the resident. The DNC stated that the back up plan was to notify the resident's Physician of changes in condition, however, Registered staff caring for the resident did not notify the resident's Physician in the absence of the Nurse Practitioner.

B. The licensee failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

Resident #003 had a medical directive ordered by the resident's Physician. The medical directive was in place and had not been discontinued. The resident's written care plan also identified the same protocol.

Staff providing care to resident #003 did not follow the medical directive over an eight day period. [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 with LTCHA, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident, and

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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or protocol, the policy or protocol was complied with.

In accordance with O. Reg. 79/10, s. 68(2)(a) and in reference to Ontario Regulation 79/10, s. 68(2)(b)(c) the licensee was required to have policies and procedures relating to nutrition care, dietary services, and hydration that identified risks related to nutrition care, dietary services and hydration with the implementation of interventions to mitigate and manage those risks.

Specifically, staff did not comply with the licensee's policy for Dietitian Referral – SV2 – V 1. The referral form directed nursing staff to complete a specific risk assessment tool when specific nutrition concerns were identified.

Resident #003 had the identified concerns for a specified time period. No risk assessment tool was completed by nursing staff for the identified time frame, which was verified by the Registered Dietitian #108. [s. 8. (1) (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 with O.Reg. 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director:
4. Misuse or misappropriation of a resident's money.

The licensee's policy, "Prevention of Abuse and Neglect", identified possible indicators of abuse. The licensee's policy directed staff to immediately report to the Director any suspicions of abuse.

Some of the indicators identified in the Licensee's policy were documented, however, there was no evidence provided to Inspector #107 that further investigation or action was taken to address concerns identified, or that the Director was notified of the potential for abuse of resident #003. [s. 24. (1) 4.]

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 with LTCHA, s. 24 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 4. Misuse or misappropriation of a resident's money, to be implemented voluntarily.

WN #4: 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 a registered dietitian who was a member of the staff of the home, completed a nutritional assessment for resident #003 when there was a significant change in the resident's health condition.

Documentation in the resident's clinical health record identified the resident had a significant change in condition.

The home's "Dietitian Referral form – SV2 – V 1" directed staff to refer to the Registered Dietitian for significant change in condition, however, a Dietitian Referral form was not completed for the change in condition. The Registered Dietitian did not complete an assessment of the resident after the change in condition.

During interview with Inspector #107, Registered Dietitian #108 confirmed that they had not been notified of the resident's change in condition through the Dietitian Referral form. The Registered Dietitian stated that they would have re-assessed the resident after the change in condition if they had been aware. [s. 26. (4) (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 with O.Reg. 79/10, 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, to be implemented voluntarily.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 13th day of January, 2020

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

Original report signed by the inspector.