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
Mar 10, 2020	2020_587129_0004	024386-19	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

PHYLLIS HILTZ-BONTJE (129)

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): February 5, 6, 10, 11, 12, 13, 18, 19, 20, 2020.

The following intake was inspected during this inspection:
024386-10 - related to falls, skin and wound care, pain management and responsive behaviour management.

During the course of the inspection, the inspector(s) spoke with resident Substitute Decision Makers, Companions providing one to one supervision, Personal Support Works, Registered Practical Nurses, Registered Nurses, Neighbourhood Coordinators, the Exercise Therapist, the Lead for Training and Orientation, the Assistant Director of Nursing Care, the Director of Nursing Care and the Assistant General Manager.

During the course of this inspection the Inspector made observations of resident environments, observation of care provided to residents, reviewed clinical records, reviewed the licensee's training records and the licensee's policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

a) The care set out in resident #001's plan of care was not provided to the resident as specified in the plan.

Resident #001 was identified to be at risk for falling and a plan of care focus was identified. Staff had identified several care interventions in order to manage this risk that were documented in the resident's plan of care.

On two identified dates, observations were made in resident #001's room and an identified care intervention that was included in the plan of care was not in place in their room. These observations were brought to the attention of Personal Support Worker (PSW) #105 and Registered Practical Nurse (RPN) #106 who acknowledged that the identified care intervention had not been implemented.
During a discussion with staff #108 they confirmed they had assessed resident #001 and determined the identified intervention would help to prevent falls and protect the resident from injury if they fell. They confirmed and documented in the clinical record that they had spoken to the resident's Substitute Decision Maker (SDM), had spoken to the nurse

on the neighbourhood and had documented this intervention in the resident's plan of care. At the time of this discussion they were not aware that the care set out in the plan of care had not been provided to the resident.

On two identified dates resident #001 was noted to be walking in the lounge area and it was noted that a second identified care intervention that was documented in the resident's plan of care was not in place.

Care as specified in the plan of care related to reducing falls and preventing injury from falls was not provided as specified in the plan of care when it was observed that two identified care interventions were not in place.

b) The care set out in resident #001's plan of care, related to pain management was not provided to the resident.

Resident #001 experienced a fall on an identified date. The resident was identified as not being able to effectively communicate their pain due to a medical condition. At the time of the fall registered staff completed a pain assessment identified as "Pain Assessment-SV" and documented that "the resident was anxious after the fall, able to complete all range of motion and some tenderness marked when moving on an identified body part. Due to the resident's cognitive status a PainAd extension assessment was completed and identified the resident's pain as level 2. The level 2 status was determined when staff indicated the resident had occasional moan or groan and the resident demonstrated sad/frightened/frown facial expressions.

Resident #001's plan of care included a care focus related to the management of pain and staff were directed to determine the appropriate pain management methods (Analgesia, TENS, hot/moist compresses, cold compresses).

The clinical record and the Director of Nursing Care (DONC) confirmed that there was no documentation in the clinical record to indicate staff had attempted to determine the most appropriate pain management method or that any action was taken to manage the pain the resident experienced following this fall.

The licensee failed to ensure that the care as specified in the plan of care was provided to the resident when staff identified the resident experienced pain at a level 2, there was no documentation that staff determined the most appropriate pain management method and no pharmaceutical or non-pharmaceutical actions were taken to manage the

resident's pain. [s. 6. (7)]

2. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

Resident #002's plan of care related to the management of identified responsive behaviours, set out a support provision that staff were to document each behavioural episode and they were to note the cause and successful support strategies, as well as include frequency and duration of the episode.

A review of behavioural documentation over a 10 day period of time, indicated that Personal Support Workers had entered a check mark to indicate the identified behaviour had been exhibited for the following times and dates:
-at 1429 hours on an identified date,
-at 2049 hours on a second identified date,
-at 0932 hours on third identified date,
-at 2106 hours on a fourth identified date, and
-at 1359 hours on a fifth identified date.

A review of the progress notes indicated that registered staff had not document each of the above noted behavioural incidents, noted the cause or successful support strategies or included the frequency and duration of the episodes, as was directed in the plan of care.

During a discussion with staff #110 on an identified date, they confirmed that there was no documentation for each of the above noted behavioural episodes as was directed in the plan of care for resident #002.

Staff did not ensure that the provision of care set out in resident #002's plan of care was documented. [s. 6. (9) 1.]

3. The licensee failed to ensure the resident was reassess and the plan of care reviewed and revised when the resident's care needs changed.

Resident #001 was identified at risk for falling and a review of clinical documentation indicated the that the resident fell on an identified date in 2019 and did not experience a fall in the following month. The clinical record indicated that the resident experienced

several falls in the next month.

Resident #001 experienced a fall on an identified date in an identified month, experienced a second fall 24 days later in the same month which resulted in the resident experiencing injuries, and fell twice on the following day of the same month.

A review of the clinical record indicated the last review of issues related to falling was completed during the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment which was locked on an identified date in the month prior to the above noted falls.

During a discussion with staff #109, the issue related to a change in the resident's care needs related to the increased number of falls they had experienced in the identified month was discussed and at this time staff #109 confirmed that there was no evidence in the clinical record that resident #001 had been reassessed or the plan of care reviewed and revised when staff became aware of an increased number of falls the resident had experienced.

Resident #001 was not reassessed, and their plan of care was not reviewed or revised when the resident's care needs changed, and the resident experienced an increased number of falls in an identified month in 2019. [s. 6. (10) (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 and ensuring that the care set out in the plan of care is provided to the resident as specified in the plan and ensuring the resident is reassess and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #001 experienced five areas of altered skin integrity following a fall they experienced on an identified date.

A review of the clinical record indicated that an initial skin assessment was completed on the day of the fall, and a weekly assessment was completed seven days later. A weekly assessment document was opened seven days later; however, no information was documented in the assessment tool.

A review of the Treatment Administration Record indicated the resident received treatment for this altered skin integrity throughout this period of time and a weekly skin assessment was completed 14 days after the last weekly assessment.

During a discussion with the DONC, they reviewed clinical documentation and confirmed that resident #001 did not have the required weekly skin assessment when the clinical record indicated the areas of skin injury the resident has sustained had not been assessed over a 14 day period of time. [s. 50. (2) (b) (iv)]

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 and ensuring that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided care to residents receive, as a condition of continuing to have contact with residents, training in other areas provided for in the regulations at times and intervals provided for in the Regulations.

In accordance with O. Reg. 79/10, s. 221(1) and for the purposes of paragraph 6 of subsection 76 (7) of the Act, falls prevention and management and skin and wound care are other areas in which training shall be provided to all staff who provide direct care to residents.

In accordance with LTCH Act 76(4) and O. Reg. 79/10, s. 219 (1) the intervals for the purpose of subsection 76(4) of the Act are annual intervals

a) The licensee failed to ensure that training in the area of falls prevention and management was provided to all staff who provided direct care to residents in 2019.

The Director of Nursing Care provided documentation that indicated 4 of 136 staff who provided direct care to residents in 2019, did not receive training in the area of falls prevention and management in 2019 and those staff continued to have contact with residents.

b) The licensee failed to ensure that training in the area of skin and wound care was not provided to all staff who provided direct care to residents in 2019.

The DONC provided documentation that indicated 6 of 136 staff who provided direct care to residents in 2019, did not receive training in the area of skin and wound care in 2019 and those staff continued to have contact with residents.

The licensee did not ensure that as a condition of continuing to have contact with resident, training in the areas of falls prevention and management as well as, skin and wound care was provided to all staff who had direct contact with residents in 2019. [s. 76. (7) 6.]

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 and ensuring that all staff who provided care to residents receive, as a condition of continuing to have contact with residents, training in other areas provided for in the regulations at times and intervals provided for in the Regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 222. Exemptions, training

Specifically failed to comply with the following:

s. 222. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services. O. Reg. 79/10, s. 222 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that persons described in clauses (1) (a) to (c) are provided with information about the items in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76(2) of the Act before providing their services.

In accordance with clauses (1) (a) to (c) of the LTCH Act 2007, “staff”, in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; (“personnel”)

In accordance with the LTCH Act 2007, c. 8, s. 76 (2):
Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents’ Bill of Rights.
2. The long-term care home’s mission statement.

3. The long-term care home’s policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home’s policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person’s responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76 (2).

Staff #102 and staff #104 were not provided with the required information before performing their responsibilities in the home.

a) On an identified date, while making observations of an identified resident, staff #102 introduced themselves as the person who was hired to provide supervision for the identified resident. They confirmed they were not a Personal Support Worker (PSW) but were a "companion" and they were an employee of an employment agency. When asked what type of training and orientation they had received prior to providing services to the identified resident, they indicated they had received training in "safety, supervision, direction and support, but it was more companionship".

Staff #111 who was identified as the lead for training and orientation was asked to provide documentation of the training and orientation staff #102 had received prior to performing their responsibilities with the identified resident . Staff #111 was unable to provided documentation to indicated that staff #102 had received any training or orientation by prior to performing their responsibilities with the identified resident.

The licensee was unable to provide training and orientation information to verify that staff #102 had been provided with training and orientation in the areas of the Residents’ Bill of Rights, the long-term care home’s policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, the protections afforded by section 26, fire prevention and safety, emergency and evacuation procedures and infection prevention and control, as was required.

b) On an identified date staff #104 introduced themselves as the person who was hired to provide one to one supervision for an identified resident. They confirmed that they were

not a Personal Support Worker but were a "companion" and they were an employee of an employment agency. Staff #102 was unable to respond when asked what training they had received prior to providing services to the identified resident . Staff #102 indicated they had been told what to do with the identified resident and what to be aware of related to the resident's responsive behaviours.

Staff #111, who was identified as the lead for training and orientation was asked to provide documentation of the training and orientation staff #104 had received before performing their responsibilities with the identified resident.

Staff #111 provided a package of information and the cover page of this packaged indicated it was a "Resource Guide -Contractors, Agency and Private Duty Aids". Staff #104 had signed an acknowledgement that they had read the "Resource Guide on September 7, 2019. Staff #111 indicated that the agency was to provide the Resource Guide-Contractors, Agency and Private Duty Aides" to any staff member they assigned to work in the home.

A review of the information contained in the Resource Guide, indicated that the packaged did not contain the long-term care home’s policy to promote zero tolerance of abuse and neglect of residents or information on emergency and evacuation procedures, did not contain complete information related to the duty under section 24 to make mandatory reports, did not contain complete information related to the protections afforded by section 26, and did not contain complete information related to fire prevention and safety.

Staff #111 acknowledged that the information contained in the Resource Guide and provided to staff #104 was not the same detailed information provided to regular staff in the home.

The licensee did not provide the required training and orientation to staff who work in the home pursuant to a contract with and employment agency before performing their responsibilities in the home. [s. 222. (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 and ensuring that persons described in clauses (1) (a) to (c) are provided with information about the items in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76(2) of the Act before providing their services, to be implemented voluntarily.

Issued on this 28th day of May, 2020

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

Original report signed by the inspector.