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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 24, 2019	2019_787640_0001	022146-18, 022600-18, 032659-18, 033560-18	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 Winston Park
695 Block Line Road KITCHENER ON N2E 3K1

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

HEATHER PRESTON (640), ZINNIA SHARMA (696)

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): January 8, 9, 10, 11, 14, 15 and 16, 2019.

This inspection was conducted concurrently with Critical Incident inspection #2019_787640_0002.

During the course of the inspection, the Inspectors observed the provision of care, reviewed clinical records, policy and procedure and conducted interviews.

The following Complaint/Critical Incident reports were inspected;

Log #022146-18 related to fall with injury
Log #022600-18 related to fall with injury
Log #032659-18 related to fall with injury
Log #033560-18 related to care and fractures

During the course of the inspection, the inspector(s) spoke with Personal Care Assistants (PCA), Registered Practical Nurses (RPN), Registered Nurses (RN), Fall Program Lead, Kinesiologist, Director of Nursing (DON), residents and families.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

A CI report submitted in December 2018, stated that resident #001 had three unwitnessed falls in December 2018.

The clinical record of resident #001 was reviewed and revealed that the resident was re-assessed after each fall but there was no documentation to indicate that different fall prevention interventions were considered in the revision of the plan of care since March 2018.

RN #106 acknowledged that different approaches were not considered for resident #001, when the fall prevention interventions in place were ineffective.

The licensee failed to ensure that different fall prevention approaches were considered for resident #001. [s. 6. (11) (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 the licensee must ensure that when a resident is reassessed and the plan of care revised because care set out in the plan is not been effective, different approaches are to be considered in the revision of the plan of care, 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 has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with.

A) In accordance with O. Reg. 79/10, s.48, that required the licensee to ensure that the interdisciplinary programs including fall prevention, were developed and implemented in the home and must include relevant policies, procedures and protocols to meet the requirements as set out in section 30.

Specifically, staff did not comply with the home's policy "Fall Prevention & Management Program", tab 04-33, that directed registered staff to initiate the Head Injury Routine (HIR) for all un-witnessed falls.

The clinical records of resident #001 indicated that they had three un-witnessed falls in December 2018.

RN #107 stated it was an expectation that HIR was to be initiated and completed for any resident who had an un-witnessed fall.

There was no documentation in resident #001's clinical records to indicate that HIR was initiated or completed after each un-witnessed fall.

RPN #110 and RN #106 acknowledged that HIR was not initiated and completed for resident #001 after each unwitnessed fall.

B) In accordance with O. Reg. 79/10, s.48, required the licensee to ensure that the

interdisciplinary programs including pain management, were developed and implemented in the home and must include relevant policies, procedures and protocols to meet the requirements as set out in section 30.

Specifically, staff did not comply with the home's policy "Pain Management Program", tab 04-48, that directed registered staff to complete and document a pain assessment when a resident or a family member reported that pain was present.

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC) regarding care that was provided to resident #001 in December 2018.

The complainant stated that on an identified date in December 2018, resident #001 was complaining of pain. As per the complainant, they had informed staff that the resident was experiencing pain.

RN #107 told the LTCH Inspector that it was an expectation that when the resident was exhibiting signs of pain, a pain assessment was to be completed.

The clinical records of resident #001 were reviewed which indicated that there was no documentation that a pain assessment was completed.

RPNs #105 and #110 acknowledged that they did not complete a pain assessment for resident #001.

The licensee failed to ensure that staff complied with the home's policies related to fall prevention and pain management. [s. 8. (1) (a),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 the licensee must ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, the licensee is required to ensure that the policy, protocol or procedure is complied with, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint was submitted to the MOHLTC indicating that resident #001 had altered skin integrity in December 2018.

The clinical records of resident #001 were reviewed and there was no documentation to show that the resident had a skin assessment completed.

RPN #110 acknowledged that a skin assessment was not completed when resident #001 exhibited an area of altered skin integrity.

The licensee failed to ensure that resident #001's altered skin integrity was assessed use a clinically appropriate assessment instrument. [s. 50. (2) (b) (i)]

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 the licensee must ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept relating to the annual evaluation of fall prevention and pain program to include the dates changes were made to the program.

a) The Fall Prevention Program annual evaluation identified the home implemented the falling leaf program and bed rail use reduction. There were no dates the changes were made to the program included in the record.
b) The Pain Program annual evaluation identified the home had implemented changes to the assessment of pain and the associated tool. There were no dates the changes were made to the program included in the record.

The DON acknowledged there were no dates that the changes to the programs had been implemented.

The licensee failed to ensure the dates of changes to the programs was included in the annual program review record. [s. 30. (1) 4.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received required training.

a) The fall prevention and management program training completed for the calendar year 2018, identified that seven percent (7%) of required staff did not participate in the required training.

b) The skin and wound care program training completed for the calendar year 2018, identified that five (5) % of required staff did not participate in the required training.

c) The pain program training completed for the calendar year 2018, identified that seven (7) % of required staff did not participate in the required training.

The DON acknowledged the home failed to ensure that all staff were provided the required training.

The licensee failed to ensure that all staff received required training in fall prevention and management, pain and skin and wound care. [s. 221. (1)]

Issued on this 4th day of February, 2019

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

Original report signed by the inspector.