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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 21, 2017	2017_536537_0025	002085-16, 002622-16, 005471-16, 008892-16, 008932-16, 018585-16, 019307-16, 019873-16, 021090-16, 022722-16, 025280-16, 030738-16, 031839-16, 033838-16, 000051-17, 000625-17, 003698-17, 003991-17, 004290-17, 005356-17, 005967-17, 008125-17, 008361-17, 009443-17	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 ASPEN LAKE
9855 McHugh Street WINDSOR ON N8P 0A6

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

NANCY SINCLAIR (537), ALI NASSER (523), ANDREA DIMENNA (669)

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): June 12, 13, 14, 15 and 16, 2017

The following Critical Incident inspections were conducted:
Related to the prevention of abuse and neglect:
Log #005967-17/CI 3037-000022-17;
Log #005356-17/CI 3037-000018-17;
Log #000051-17/CI 3037-000001-17;
Log #005471-16/CI 3037-000003-16;
Log #003991-17/CI 3037-000014-17;
Log #002622-16/CI 3037-000007-16;
Log #000625-17/CI 3037-000005-17;
Log #004290-17/CI 3037-000015-17;
Log #025280-16/CI 3037-000044-16;
Log #033838-16/CI 3037-000071-16;
Log #008892-16/CI 3037-000008-16;
Log #019873-16/CI 3037-000037-16;
Log #003698-17/CI 3037-000012-17;
Log #018585-16/CI 3037-000033-16;
Log #008932-16/CI 3037-000020-16;

Related to a missing or unaccounted for controlled substance:
Log #008125-17/CI 3037-000027-17;
Log #008361-17/CI 3037-000029-17;

Related to medication administration:
Log #009443-17/CI 3037-000007-17;

Related to falls prevention:
Log #030738-16/CI 3037-000059-16;
Log #021090-16/CI 3037-000029-16;
Log #022722-16/CI 3037-000018-16;
Log #031839-16/CI 3037-000056-16;
Log #019307-16/CI 3037-000035-16;
Log #002085-16/CI 3037-000005-16;

**During the course of the inspection, the inspector(s) spoke with The General Manager (GM), Director of Nursing Care (DONC), one Neighbourhood Coordinator, two Registered Nurses (RN), five Registered Practical Nurses (RPN), one Resident Assessment Instrument Coordinator (RAI), 14 Personal Support Workers (PSW), one Personal Expression Resource Team (PERT) PSW, one Housekeeping Aide, one Laundry Aide, one Food Services Aide,
and Residents.**

The inspector(s) also observed resident rooms and common areas, medication storage areas and medication administration, reviewed health care records and plans of care, reviewed assessments, policies and procedures, training records, critical incidents and the home's internal investigation reports.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Legendé 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 has failed to ensure that the written plan of care for a resident set out clear direction to staff and others who provided direct care to the resident.

a) A Critical Incident system report (CIS) submitted by the home indicated an injury to an identified resident.

The care plan for the resident indicated a transfer focus with specific interventions.

Interview was conducted with a Personal Support Worker (PSW), who stated that the resident was transferred with a specific intervention since the resident had been injured. A PSW stated that there was a logo inside the cabinet in the bathroom that indicated the transfer type for the resident. The PSW also stated that a copy of the "Personal Care Profile" was located in the binder with the resident flow sheets and would indicate the transfer status. The "Personal Care Profile" located in the binder for the resident, specified a transfer different from what the PSW stated. A PSW indicated that the "Personal Care Profile" needed to be changed as it was not correct. The PSW stated that there were no other care plans available for review for direction.

Interview was completed with a Registered Practical Nurse (RPN) regarding how a resident was assessed for transfers. The RPN stated that on admission, or with a change in status, the Exercise Therapist completed an assessment to determine the appropriate transfer status. The RPN stated that if the staff determined the current status was no longer appropriate, they could increase the transfer status and then would consult the Exercise Therapist to do a full assessment, but staff could not decrease the level of a

transfer status. The RPN stated that the identified resident had been assessed for a specific transfer since the incident of injury to the resident.

Observation of the logo in the bathroom cabinet for the identified resident indicated a transfer logo consistent with the transfer interventions as stated by the PSW and RPN. The resident stated they were transferred by staff in a manner consistent as stated by the RPN and PSW and the tranfer logo present in the bathroom cabinet.

Director of Nursing Care (DONC) stated that the home's Exercise Therapist completed the assessments to determine the transfer status of a resident. A progress note completed by the Exercise Therapist for the identified resident stated that the resident transfer status was as indicated by the resident, the PSW, RPN and the logo and was to continue indefinitely. The DONC stated the assessment status should be recorded in the written care plan and that staff should follow the printed care plan in the resident's chart. The DONC stated that there should be a logo posted in the bathroom cabinet that was consistent with the assessed transfer status. The DONC stated that the registered staff were to complete the "Personal Care Profile" quarterly, including transfer status based on the assessment of the Exercise Therapist. The "Personal Care Profile" present for the identified resident was reviewed and the DONC stated that the direction on the Personal Care Profile was incorrect to the assessed need of the resident.

b) A Critical Incident system report (CIS) stated that an identified resident had verbalized concerns regarding how care had been provided to them. As a result of this, the home initiated an internal investigation. Discussion with the Power of Attorney (POA) for the resident regarding the incident determined the resident's usual routine and preferences for care. As a result, a document was drawn up that stated the resident's usual routine and preferences for care. The document was placed in a binder along with the flow sheets for the resident that were completed daily by the Personal Support Workers who provided care for this resident.

Review of the care plan for the resident stated a specific routine for care and referenced an additional binder for direction on how to provide the care. The binder that staff were directed to review for the specific routine for the care was reviewed and was not consistent with the written plan of care or with the document in the flow sheet binder.

Interview was conducted with a Personal Support Worker (PSW) who stated a specific care routine for the resident. The PSW was shown the document in the flow sheet binder and stated they were not aware of the document and the specific directions for

care in the document. The PSW stated that they would look at the additional binder for direction on the care to be provided, and not the written plan of care. The care routine stated by the PSW was not consistent with the written plan of care or the document in the flow sheet binder.

A Registered Practical Nurse (RPN) stated during interview that the care routine was in the binder. Review of the binder and directions for care indicated a specific care routine. The RPN stated they were not aware of the document or of its directions for care located in the binder with the flow sheets. The RPN stated that a paper copy of the care plan was printed and kept in the front of the individual chart for each resident in the charting room on each floor, and this was the care plan that was available to the staff to review. The RPN reviewed the care plan in the resident chart and stated that the direction in the printed care plan was not the same as the care direction in the binder, and was different again than the document in the flow sheets.

Director of Nursing Care (DONC) stated during interview that the written care plan in the resident's chart was the care plan that staff were expected to follow. DONC stated that the binder and the care plan should have had the same direction. DONC also stated that the document with the flow sheets should have been removed from the flow sheet binder for the resident.

DONC stated that the expectation was that the written plan of care for a resident should set out clear direction to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. 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 Critical Incident system report (CIS) submitted by the home, identified an incident involving the resident when specific care interventions had not been followed.

An identified resident was observed on two occasions with the specific medical devices for safety in place.

The home's incident report was reviewed and stated that a Registered Practical Nurse (RPN) had witnessed an incident involving the identified resident.

The home's investigation notes were reviewed, including the General Manager (GM)

notes from an interview with a Personal Support Worker (PSW). The notes identified that two PSWs had provided personal care to the resident. After the care was completed, a PSW stated that one of the two specified medical devices for safety had been applied.

A Neighbourhood Coordinator was interviewed, and acknowledged that the resident was unable to release their own medical device for safety and had not had any further similar incidents.

A PSW was interviewed, and recalled the incident involving the resident. The PSW stated they recalled having implemented one of the two medical devices for safety themselves and thought the other PSW present had implemented the second medical device for safety. The PSW said that they knew the required medical devices for safety for the resident, and that these interventions could be found in the resident's care plan and were posted on signs in the resident's room.

The GM was interviewed and stated that it was the home's expectation that interventions included in a resident's plan of care were implemented. The GM said the resident's medical devices for safety had not been implemented.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this or similar legislation being issued in the home on November 4, 2016 as a Voluntary Plan of Correction (VPC) in a Critical Incident inspection, January 4, 2016 as a Voluntary Plan of Correction during the home's Resident Quality Inspection, December 15, 2015 as a Voluntary Plan of Correction during a Complaint inspection, October 6, 2015 as a Voluntary Plan of Correction during a Complaint inspection, and January 22, 2015 as a Voluntary Plan of Correction during a Critical Incident inspection. [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 care set out in the plan of care is provided to the resident as specified in the plan and that the written plan of care for a resident sets out clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 21st day of June, 2017

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

Original report signed by the inspector.