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 # / No de registre	Type of Inspection / Genre d'inspection
Sep 21, 2018	2018_533115_0017	016398-18	Resident Quality Inspection

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

TERRI DALY (115), CAROLEE MILLINER (144), CASSANDRA TAYLOR (725)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 13, 14, 15, 16, 20, 21, 22, 23, & 24, 2018

The following Critical Incident intakes were completed within this inspection:
Related to falls prevention:
Critical Incident Log #015346-18/CI 3037-000033-17
Critical Incident Log #020943-17/CI 3037-000056-17
Critical Incident Log #015217-17/CI 3037-000041-17
Critical Incident Log #026941-17/CI 3037-000065-17

Critical Incident Log #003361-18/CI 3037-000009-18
Critical Incident Log #001613-18/CI 3037-000004-18
Critical Incident Log #000358-18/CI 3037-000001-18
Critical Incident Log #010161-18/CI 3037-000026-18
Critical Incident Log #008284-18/CI 3037-000019-18
Critical Incident Log #014697-18/CI 3037-000032-18
Critical Incident Log #012081-18/CI 3037-000029-18
Critical Incident Log #009300-18/CI 3037-000025-18.

Related to the prevention of abuse and neglect:
Critical Incident Log #019313-17/CI 3037-000052-17
Critical Incident Log #020405-17/CI 3037-000054-17
Critical Incident Log #016457-17/CI 3037-000043-17
Critical Incident Log #012642-17/CI 3037-000038-17
Critical Incident Log #022753-17/CI 3037-000062-17
Critical Incident Log #011481-17/CI 3037-000037-17
Critical Incident Log #014543-18/CI 3037-000031-18
Critical Incident Log #008069-18/CI 3037-000021-18
Critical Incident Log #012496-18/CI 3037-000027-18
Critical Incident Log #002574-18/CI 3037-000006-18.

Related to controlled substance missing/unaccounted for:
Critical Incident Log #003330-18/CI 3037-000010-18.

The following Complaint intakes were completed within this inspection:
Complaint Log #017692-17/ IL-52179-LO related to care concerns
Complaint Log #002107-18 related to Long Term Care home complaint/response.

During the course of the inspection, the inspector(s) spoke with more than twenty residents, a Residents' Council representative, a Family Council representative, the General Manager, the Director of Care, two Assistant Directors of Care, a Registered Dietitian, the Maintenance Manager, the maintenance worker, the Exercise Therapist, two Recreation Aides, three Registered Nurses, eleven Registered Practical Nurses, two Housekeeping Aides, eleven Personal Support Workers, and family members.

During the course of the inspection, the inspectors toured all resident home areas,

observed the general maintenance and cleanliness of the home, medication administration and narcotic storage, the provision of resident care, recreational activities, staff to resident interactions, infection prevention and control practices and reviewed resident clinical records, the posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
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	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and not neglected by the licensee or staff.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means,
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or
(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. ("mauvais traitement d'ordre verbal") O. Reg. 79/10, s. 2 (1).

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), describing an incident of staff to resident verbal abuse, involving Personal Support Worker (PSW) #127 and residents #036, #037 and #038.

Included in the CIS report Recreational Aide #128 witnessed three different inappropriate verbal exchanges between resident #038 and PSW #127 on a specific date.

Review of the homes policy subject: Prevention of Abuse and Neglect indicates that the home has a zero tolerance for abuse and neglect towards residents.

During an interview with the Assistant Director of Care (ADOC) #111 it was stated that Recreational Aide #128 wrote their concerns down and placed it in the Manager of Recreations mailbox, which was not seen until the next day as the manager was off that particular evening.

During an interview with Recreation Aide #131, Maintenance staff #130, PSW #114, RPN #107, RPN #108 and RN #122 they all indicated that abuse should be reported immediately.

During an interview with the ADOC #111 it was stated that Recreation Aide #128 should have intervened and immediately reported the verbal abuse to the charge nurse on duty.

The licensee has failed to ensure that resident #036, #037 and #038 were protected from verbal abuse. [s. 19. (1)]

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 residents are protected from verbal abuse by anyone, to be implemented voluntarily.

WN #2: 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

s. 24. (2) Every person is guilty of an offence who includes in a report to the Director under subsection (1) information the person knows to be false. 2007, c. 8, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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 was based to the director: 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.

Review of the homes policy subject: Prevention of Abuse and Neglect indicates that the home has a zero tolerance for abuse and neglect towards residents. The policy also states "All team members, students and volunteers who witness or suspect the abuse of a resident, or receive complaints of abuse, are required to report the matter immediately to any supervisor including the charge nurse, or any member of leadership team."

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), describing an incident that occurred on a specific date, of staff to resident verbal abuse, involving Personal Support Worker (PSW) #127 and residents #036, #037 and #038.

Included in the CIS report Recreational Aide #128 witnessed PSW #127 verbally abuse residents' #036, #037 and #038 at different times during the shift.

During an interview with the Assistant Director of Care (ADOC) #111 it was stated that Recreational Aide #128 wrote their concerns down and placed it in the Manager of Recreations mailbox, which was not seen until the next day as the manager was off this particular evening.

During an interview with Recreation aide #131, Maintenance #130, PSW #114, RPN #107, RPN #108 and RN #122 they all indicated that abuse should be reported immediately.

During an interview with the ADOC #111 it was stated that Recreation Aide #128 should have intervened and immediately reported the verbal abuse to the charge nurse on duty for residents #036, #037 and #038. ADOC #111 stated that the incident should have been reported immediately via the after-hours pager.

The licensee has failed to immediately report witnessed verbal abuse of residents #036, #037 and #038. [s. 24. (1)]

2. A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), describing an alleged incident that occurred on a specific date, of staff to resident sexual abuse, involving Personal Support Worker (PSW) #119 and resident #022.

Included in the CIS report, resident #022 asked PSW #135 if residents were able to refuse care from staff. When PSW #135 inquired why resident #022 would want to refuse

care, resident #022 reported PSW #119 asked resident #022 an inappropriate question, while providing care.

During an interview with the Assistant Director of Care (ADOC) #111 it was stated PSW #135 reported to Registered Nurse (RN) #136. RN #136 then left a voice mail on ADOC #111's voice mail requesting a return call in the morning. ADOC #111 stated that a return call was made several days later to RN #136 and at that time RN #136 reported the allegations of abuse.
During an interview with Recreation aide #131, Maintenance #130, PSW #114, RPN #107, RPN #108 and RN #122 they all indicated that abuse should be reported immediately.

During an interview with the ADOC #111 is was stated that the incident should have been immediately reported to the MOHLTC via the after hours pager.

The licensee had failed to immediately report alleged sexual abuse of resident #022. [s. 24. (1)]

3. A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC). The CIS report stated that on a specific date, RPN#125 reported to Registered Nurse #122 that they were unable to locate medications for resident #041, the RN came to the neighbourhood to assist the RPN in a search for the medications. A search of the garbage resulted in the staff finding several resident medications intact in the cellophane packages as provided by the pharmacy. The packages which were from various medication administration passes were found rolled up inside a number of blue disposable gloves.

A review of the home's investigative notes indicated that Registered Practical Nurse (RPN) #125 had admittedly acknowledged that they had discarded the resident's medications as they had gotten behind and busy.

During an interview with the General Manager #118 they acknowledged that the incident should have been reported immediately to the MOHLTC via the after hours pager on a specific date.

The licensee had failed to immediately report neglect towards several residents at the home. [s. 24. (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 to ensure that a person who has reasonable grounds to suspect that 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, has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent (%) of body weight, or more, over one month.

The home's Weight and Monitoring Policy last reviewed March 3, 2018, included the following directives:
When a weight loss or gain of more than 2 kilograms (kg) or more than 5% is noted from the previous month, the PCA will reweigh the resident immediately to ensure the weight is correct.

When the reweigh confirms there is: 5% undesirable/unplanned weight change in one

month, the team leader will complete the Request for Nutrition Consultation form (Food Services, Tab 07-41), and give/send to the director of food services (DFS) and registered dietitian.

Resident #003 was admitted to the home on a certain date, with a specific weight. The resident was noted to have a weight loss over a specific period of time, which according to the home's policy would have required them to be reweighed.

A review of the clinical record for resident #003, did not reflect that the resident was reweighed, and as of specific date, had not been referred to the Registered Dietitian.

PSW #109 told the inspector that when there was a weight discrepancy of 2 kg from one weight to the next weight, the resident was reweighed and if the discrepancy was confirmed, the RPN was notified.

RPN #110 said that when PSW's and RPN's entered resident weights into the Point of Care (POC) program, the program flagged weight discrepancies of 2 kg or 0.5% and sets up an alert for the RD who would have access to the report on their next visit to the home.

DOC #100 and ADOC #103 further reinforced that the home's protocol directed staff to reweigh residents with a weight discrepancy of 2kg or 0.5% and if the discrepancy remained, the RPN would initiate a referral to the RD.

ADOC #103 also advised that when resident weights were entered into the POC program, the program was designed to set up an alert for the RD if a resident's weight differed from one month to the next by 2kg or 0.5% and that the RD would have access to the information on their next visit to the home.

DOC #100 and ADOC #103 agreed that resident #003 was not reweighed after a weight discrepancy and that a referral was not made to the RD.

DOC #100 advised that one RD had been on site in the home on a specific date, and that the RD did not complete an assessment for resident #003.

The licensee failed to ensure that one resident with a weight change of 5 per cent of body weight, or more, over one month, was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated. [s. 69. 1.,s. 69.

2.,s. 69. 3.,s. 69. 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 to ensure that residents with weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of the home's Medication Incident Report # MIR-10088 showed that an error of medication omission occurred on a specific date involving resident #012.
Review of the clinical record for resident #012 included an order for a specific medication. The electronic Medication Administration Record (eMAR) included documentation by staff signature to support that the medication had been administered to resident #012 at a specific time on a specific date. On the afternoon shift, the scheduled Registered Practical Nurse could not locate the strip package medication for resident #012, the Registered Nurse on duty assisted in helping the RPN look for the medications and it was discovered that the medication for this resident had been discarded into the garbage.

As a result an investigation followed and the registered staff member who had worked a particular shift and who had signed that the medication was given, admitted that they had

not administered the medication and had disposed it into the garbage still in the strip cellophane packaging from the pharmacy.

The Director of Care #100 explained that the incident investigation concluded that the staff member named in the incident had signed a medication that had not been administered. [s. 131. (2)]

2. A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care. The CIS report stated that on a specific date RPN #125 reported to Registered Nurse #122 that they were unable to locate medications for resident #041, the RN came to the neighbourhood to assist the RPN in a search for the medications. A search of the garbage resulted in the staff finding several resident medications intact in the cellophane packages as provided by the pharmacy. The packages which were from various medication administration passes were found rolled up inside a number of blue disposable gloves.

Medication Administration Records (eMAR) for a specific date for several residents included documentation by staff signature to support that the following resident's medications had been administered.

A review of the home's investigative notes indicated that Registered Practical Nurse (RPN) #126 had admittedly acknowledged that they had discarded several resident's medications as they had gotten behind and busy.

An interview with RN #122 they remembered the incident in which they were called to the neighbourhood to assist RPN #125 in the search for a resident's medication. RN #122 noted when they checked the garbage they found several blue disposable gloves tied and wrapped into a ball, when they opened the gloves they found several resident's individual cellophane packaged medication strips intact and containing medications from specific dates and medication passes, including resident #041's medications which the RPN was able to administer.

A telephone interview was conducted with RPN #125, the staff member acknowledged that they initially could not locate resident #041's medications, and upon further investigation had discovered the incident where several resident's medications from the previous shift, including resident #041's medications were found in the garbage wrapped up in a ball of 8 blue disposable gloves, the medications were still intact in the packaging from pharmacy.

An interview with DOC #100 they acknowledged the incident and that several residents did not receive medication on specific dates in accordance with the directions for use by the prescriber. [s. 131. (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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 4th day of October, 2018

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

Original report signed by the inspector.