Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date May 31, 2022
Inspection Number 2022_1465_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Schlegel Villages Inc.

Long-Term Care Home and City
The Village of Aspen Lake, Windsor

Lead Inspector
Samantha Perry #740

Inspector Digital Signature
Samantha Perry
2022.06.03 07:58:17 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 04, 05, 06, 09, 10, 11, 12, 13, 16, 17, 18, 2022.

The following intake(s) were inspected:

- Intake # 001383-22 (Complaint) related to resident care concerns and;
- Intake # 003125-22 (Complaint) related to resident care concerns and death.

The following **Inspection Protocols** were used during this inspection:

- Continence Care
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Skin and Wound Prevention and Management

INSPECTION RESULTS

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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

WRITTEN NOTIFICATION NUTRITION CARE AND HYDRATION PROGRAMS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 79/10, s. 68. (2) (b)(c).

The licensee has failed to ensure that any risk associated with resident #001's decrease in nutrition and hydration was identified and interventions were implemented to mitigate and manage those risks.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint related to resident care concerns and death.

A review of resident #001's clinical records related to nutrition and hydration documented a decrease in the resident's overall intake. Additional review of resident #001's clinical records showed there was no documentation of a referral to the Registered Dietitian or allied healthcare staff for an assessment of the resident's sudden decrease in food and fluid intake. Therefore, the identification of any associated risks to the resident were not identified and the implementation of any interventions to mitigate and manage any identified risks were not established, as per the legislation.

Registered Dietitian #112 said, the sudden and prolonged decrease in resident #001's food and fluid intake should have been a red flag for staff, and they would have expected to be notified of the resident's change in eating and drinking habits.

There was an increased risk to resident #001 when the licensee failed to notify the registered dietitian of the sudden decrease in the resident's food and fluid intake.

Sources: Resident #001's clinical records and interviews with staff.

WRITTEN NOTIFICATION REPORTS RE CRITICAL INCIDENTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 79/10 s. 107 (1) 2.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances, of a resident's unexpected death, followed by the report required under subsection (5).

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint related to a resident's care concerns and death.

The home's policy titled "Death Pronouncement" defines an "Expected Death" as a death that was imminently anticipated generally as a result of a progressive end-stage terminal illness.

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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

A review of resident #001's clinical records showed no documented record that the resident was palliative or that their death was imminently anticipated. Several other clinical records were reviewed and documented the resident was their normal self, including certain behaviours normally exhibited by resident #001, lab results, ongoing scheduled personal medical appointments and registered staffs' assessments of the resident up until the day of their death.

In interviews multiple staff members said, the resident was their normal self, nothing out of the ordinary in the days and the morning leading up to resident #001's death. They said they were surprised when they found out the resident had passed away. Further supporting there was no indication the resident's death was imminently anticipated.

Sources: Resident #001's clinical records, the home's "Death Pronouncement" policy and interviews with staff.