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

London Service Area Office
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Original Public Report

Report Issue Date August 17, 2022
Inspection Number 2022_1465_0002
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
Terri Daly #115

Additional Inspector(s)
Debra Churcher #670
Cassandra Taylor #725

Choose an item.

Terri Daly
Digitally signed by Terri Daly
Date: 2022.08.17 15:24:42 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 14, 15, 18-22, and 25-27, 2022.

The following intake(s) were inspected:

- Intake # 000833-22 CIS # 3037-000003-22 related to falls prevention.
- Intake # 001447-22 CIS # 3037-000007-22 related to falls prevention.
- Intake # 002287-22 CIS # 3037-000009-22 related to falls prevention.
- Intake # 009624-22 Complaint related to responsive behaviours.
- Intake # 009615-22 Complaint related to safe and secure home.
- Intake # 011949-22 Complaint related to care and services.

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

- Continence Care
- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Pain Management
- Responsive Behaviours
- Safe and Secure Home
- Skin and Wound Prevention and Management

INSPECTION RESULTS

During this inspection, the inspector(s) made relevant observations, reviewed records, and conducted interviews, as applicable. There were *findings of non-compliance*.

WRITTEN NOTIFICATION SKIN AND WOUND CARE

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

Non-compliance with: O. Reg. 79/10 s. 50(2)(b)(i) under the Long-Term Care Homes Act.

The licensee has failed to ensure that a specific resident received 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 assessments when they returned to the home from the hospital exhibiting altered skin integrity.

Rationale and Summary

On a specific date, the resident had sustained injuries from an incident which required them to be transferred to the hospital. The resident returned from the hospital to the home after having treatment. Upon return to the home a head-to-toe assessment was completed, and noted altered skin integrity to three different areas. No skin and wound assessments were found for; three different areas of altered skin integrity.

A Registered Practical Nurse indicated that an assessment was to be completed the same day as when the altered skin integrity was noted.

Review of the home's skin and wound policy; Manual: Nursing, Section: CARE, Subject: Skin and Wound Care Program Tab 04-78, stated in part that an assessment of altered skin integrity would take place using the skin and wound evaluation tool.

The Wound Care Champion (WCC) and Director of Nursing Care (DNC) indicated that skin and wound assessments should be completed as soon as possible after noting the alteration in the skin. Both the WCC and DNC reviewed the resident's chart and indicated no assessment was completed and should have been.

Sources: a resident's records, the home's skin and wound care policy and staff interviews.

[INSP #725]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

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

Non-compliance with: O. Reg. 246/22 s. 55. (2)(b)(ii) under FLTCA.

The licensee has failed to ensure that a specific resident, who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Rationale and Summary
Review of the resident's skin and wound assessments showed altered skin integrity on a specific date.

Review of the homes investigation notes, showed an interview with Personal Support Worker (PSW) who stated that they recognized areas of altered skin integrity, and forgot to notify the registered staff.

The homes Skin and Wound Care policy, under the Personal Support Worker heading, stated, "Recognizes and reports resident changes in skin comfort and Reports and documents abnormal or unusual skin concerns to the registered nursing team member, including but not limited to red or open areas, blisters, bruises, tears, scratches".

In an interview with the General Manager (GM) they stated that the PSW should have reported their observations to the registered staff on that same day they noted the areas of altered skin integrity.

There were no initial skin or wound assessments completed and therefore the resident did not receive immediate treatment related to these areas of altered skin integrity.

Sources: A resident's clinical record, the homes internal investigation notes, the home's skin and wound policy and an interview with the GM.

[INSP #670]

WRITTEN NOTIFICATION SKIN AND WOUND

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 50(2)(b)(iv) under the Long-Term Care Homes Act, and O. Reg. 246/22 s. 55. (2)(b)(iv) under FLTCA.

On April 11, 2022, the *Fixing Long-Term Care Act, 2021* (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the *Long-Term Care Homes Act, 2007* (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under O.

Reg. 79/10 s. 50(2)(b)(iv). Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under O. Reg. 246/22 s. 55. (2)(b)(iv) under the FLTCA.

Non-compliance with: O. Reg. 79/10 s. 50(2)(b)(iv) under the Long-Term Care Homes Act.

The licensee has failed to ensure that a specific resident's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A resident was identified as having several areas of altered skin integrity requiring monitoring.

A Registered Practical Nurse (RPN) indicated that an assessment was to be completed weekly when a resident was noted to have altered skin integrity.

This resident's assessments were reviewed, and weekly assessments were not completed for the certain areas of altered skin integrity on specific dates.

Review of the home's skin and wound policy; Manual: Nursing, Section: CARE, Subject: Skin and Wound Care Program Tab 04-78, stated in part that staff were to reassess the altered skin integrity at least weekly and as needed using the skin and wound evaluation.

The Wound Care Champion (WCC) and Direction of Nursing Care (DNC) indicated that alterations in skin integrity should have been reassessed weekly. Both the WCC and DNC reviewed the resident's chart and indicated no assessment was completed for the identified altered skin integrity for the time identified and should have been.

Sources: A resident's records, the home's skin and wound care policy, and staff interviews.

[INSP #725]

Non-compliance with: O. Reg. 246/22 s. 55. (2)(b)(iv) under the FLTCA.

The licensee has failed to ensure that a specific resident, who was 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.

Rationale and Summary
Review of the resident's progress notes on a specific date stated the resident had two areas of altered skin integrity.

Review of the resident's Treatment Administration Records (TARs) did not show an intervention to monitor these specific areas of altered skin integrity.

Review of homes policy titled Skin and Wound Care Program, under the Nursing Registered Practical Nurse (RPN) tab stated, "Reassesses altered skin integrity at least weekly if clinically indicated and as needed using the skin and wound evaluation".

In an interview with the homes Wound Care Lead (WCL) they stated that they were also unable to locate any skin and wound assessments for this resident and that they should have been completed upon discovery of the altered skin integrity and then weekly until resolved.

Sources: This resident's progress notes and TARs, the homes skin and wound policy and interview with WCL #120.

[INSP #670]

WRITTEN NOTIFICATION RESIDENT RECORDS

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 274(b) under the FLTCA.

The licensee has failed to ensure that a specific resident's written record was kept up to date at all times.

Rationale and Summary
Review of the resident's weekly skin and wound assessments for three areas of altered skin integrity showed that the areas of altered skin integrity identified were resolved on a specific date.

Review of the resident's Treatment Administration Records (TARs) showed an intervention that stated to complete a specific treatment daily. This intervention was signed as being completed on specific dates passed the date where the assessment noted it was resolved.

In an interview the Wound Care Lead (WCL) stated that the areas of altered skin integrity were resolved on specific dates and the treatments should have been discontinued in the TAR's and that the staff were not doing the treatments but were just signing for them.

Sources:
The resident's skin and wound assessments and TAR's and interview with the WCL.

[INSP #670]

COMPLIANCE ORDER [CO#001] MAINTENANCE SERVICES

NC#005 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 O. Reg. 246/22 s. 96. (2)(b)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s. 96. (2)(b)
Specifically, the licensee must:

a) Update the home's policy to include a process to ensure all slings are kept in a good state of repair.
b) Complete monthly audits for three months on all slings in the home.
c) Keep a record of all audits and document any deficiencies found and any corrective actions taken.
d) Retrain two specific PSW's, on using lift and transfer equipment including but not limited too, sling inspection and reporting slings not found in a good state of repair.
e) Follow the manufacturer's instructions related to sling inspection for a specific resident.

Grounds

Non-compliance with: O. Reg. 246/22 s. 96. (2)(b)
The licensee has failed to ensure that the home's procedures were developed and implemented to ensure that resident lift and transfer slings were kept in good repair.

Rationale and Summary
A complaint was made to the Ministry of Long-Term Care relating to an incident that occurred on a specific date, during a resident transfer.

A review of the resident's progress notes which included a specific incident note on a specific date, indicated the resident had an incident during a transfer.

An observation of the equipment used during the incident showed that it was not in a state of good repair. The manufactures label was no longer attached to the equipment.

A general observation and inspection of similar equipment on a specific date showed two other pieces of equipment not in a state of good repair. A Personal Support Worker (PSW), stated that neither of these pieces of equipment were currently in use but should have been removed for safety reasons.

Three PSW's during interviews all indicated that they check equipment prior to use but that there was no process to document the checks. They also all indicated that if this specific equipment was not in a good state of repair that they would remove and give them to management or the Exercise Therapist.

The home's policy Tab# 06-24 of the Nursing Manual, Section: Safety, titled "Lifts – Operation and Maintenance" revised May 2022, stated that "It is the policy of Schlegel Villages to ensure the safety of residents and team members through proper operation and maintenance of lifts."

And that, "All team members will examine slings and lifts before using them. A pre-start-up inspection will be completed by team members on designated equipment to ensure lift safety. (See Occupational Health and Safety – Tab 07-15.) All defective equipment must be removed immediately, tagged out, and reported to the director of environmental service."

"Slings must not be bleached as this weakens the fabric. Frayed slings must be taken out of circulation and returned to the kinesiologist/exercise therapist or designate for replacement."

The General Manager (GM), provided a copy of the manufacturer's instructions/user manual for the specific equipment, the same equipment that was being used for this specific resident during the incident.
The manual documented for sling inspection that:
"Slings should be inspected prior to use and after washing. Damaged or badly worn slings should be discarded… The label on the sling contains vital information to identify the sling – if any part of the label becomes illegible, then it must be removed from service and replaced."
The manual also included detailed information about what should be noted when a sling is visually inspected.

In an interview the Exercise Therapist they stated that the equipment had not been inspected since 2019 when an external contracted company completed an audit. The Exercise Therapist indicated that staff were told in training to inspect the equipment prior to using on a resident but that this information was not documented anywhere. The staff member was unaware of any policy or procedure that provides direction related to the maintenance of this equipment.

In an interview the Director of Nursing Care (DNC), they stated that there was a policy in place related to safety for lift equipment maintenance but that it was not being followed and should have been. They indicated that all lift equipment including slings should be inspected prior to use, removed from the neighbourhood, and replaced if it shows signs of wear, rips, fraying, loosened stitching etc., to ensure resident safety during lift and transfers.

Sources: observations, staff interviews, the home's safety and lift policy and the manufacturer's user manual.

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[INSP #115]

This order must be complied with by September 2, 2022

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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LondonSAO.moh@ontario.ca

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.