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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 4, 2017	2017_508137_0011	018072-15, 005465-16, 005655-16, 006030-16, 007181-16, 008598-16, 008950-16, 009677-16, 010458-16, 012682-16, 014897-16, 015323-16, 016035-16, 018579-16, 018582-16, 018588-16, 019168-16, 020550-16, 021141-16, 021806-16, 022067-16, 022525-16, 023762-16, 024622-16, 026464-16, 026608-16, 030400-16, 030625-16, 031285-16, 031587-16, 031938-16, 032428-16, 033197-16, 033937-16, 034340-16, 034428-16, 035135-16, 000131-17, 000155-17, 000158-17, 000353-17, 002249-17, 004080-17, 004387-17, 004863-17, 005893-17, 007406-17, 008804-17, 008907-17	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 at St.Clair
1800 Talbot Road WINDSOR ON 000 000

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

MARIAN MACDONALD (137), ALISON FALKINGHAM (518), CAROLEE MILLINER (144)

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 5-9 and June 12-13, 2017

The following Critical Incident System (CIS) reports were completed during this inspection:

Falls Prevention
CIS 3046_000016_16 / Log # 034428-16
CIS 3046_000043_16 / Log # 015323-16
CIS 3046_000049-16 / Log # 021141-16
CIS 3046_000069_16 / Log # 022526-16
CIS 3046_000081_16 / Log # 026464-16
CIS 3046_000083_16 / Log # 026608-16
CIS 3046_000091_16 / Log # 030625-16
CIS 3046_000094_16 / Log # 031938-16
CIS 3046_000095_16 / Log # 031587-16
CIS 3046_000111_16 / Log # 035135-16
CIS 3046_000010_17 / Log # 002249-17
CIC 3046_000014_17 / Log # 004387-17
CIS 3046_000016_17 / Log # 004863-17
CIS 3046_000017_17 / Log # 005893-17

CIS 3046_000025_17 / Log # 008804-17
CIS 3046_000026_17 / Log # 008907-17

Improper Care/Neglect
CIS 3046_000074_16 / Log # 024622-16
CIS 3046_000092_16 / Log # 030400-16
CIS 3046_000113_16 / Log # 000131-17
CIS 3046_000003_17 / Log # 000158-17
CIS 3046_000012_17 / Log # 004080-17

Medication
CIS 3046_000061_16 / Log # 020550-16

Visitor to Resident Abuse
CIS 3046_000027_16 / Log # 008950-16
CIS 3046_000036_16 / Log # 012682-16
CIS 3046_000098_16 / Log # 032428-16
CIS 3046_000002_17 / Log # 000155-17

Staff to Resident Abuse
CIS 3046_000016_16 / Log # 005655-16
CIS 3046_000018_16 / Log # 006030-16
CIS 3046_000031_16 / Log # 010458-16
CIS 3046_000054_16 / Log # 018582-16
CIS 3046_000055_16 / Log # 018579-16
CIS 3046_000060_16 / Log # 022067-16
CIS 3046_000066_16 / Log # 021806-16
CIS 3046_000071_16 / Log # 023762-16
CIS 3046_000096_16 / Log # 031285-16
CIS 3046_000100_16 / Log # 033197-16

Resident to Resident Abuse
CIS 3046_000003_16 / Log # 005465-16
CIS 3046_000107_16 / Log # 034340-16
CIS 3046_000005_17 / Log # 000353-17

Resident to Resident Abuse
CIS Inspection completed but not identified on report:

CIS 3046_000108_16 / Log # 034346-16

Resident to Resident Abuse
The following CIS reports are identified in the report but were NOT inspected at this time:
CIS 3046_ 000145_15 / Log # 018072-15
CIS 3046_000023_16 / Log # 008598-16
CIS 3046_000029_16 / Log # 009677-16
CIS 3046_ 000041_16 / Log # 014897-16
CIS 3046_000046_16 / Log # 016935-16
CIS 3046_000056_16 / Log # 018588-16
CIS 3046_000058_16 / Log # 019168-16
CIS 3046_000103_16 / Log # 033927-16
CIS 3046_000022_17 / Log # 007406-17
SAC Report 11528 – No CIS submitted / Log # 007181-16

During the course of the inspection, the inspector(s) spoke with General Manager, Director of Care, two Assistant Directors of Care, four Neighbourhood Coordinators, Registered Dietitian, Physiotherapist, two Physiotherapy Assistants, Kinesiologist, Recreation Assistant, two Registered Nurses, 11 Registered Practical Nurses, 16 Personal Support Workers, 47 residents and family members.

The Inspectors also observed resident care provision, resident/staff interactions, lifting/transferring techniques, reviewed residents' clinical records, internal investigative reports, education/training records and relevant policies.

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

During the course of this inspection, Non-Compliances were issued.

5 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for an identified resident set out clear directions to staff and others who provided direct care to the resident.

Upon return from hospital, the Minimum Data Set (MDS) assessment, for an an identified resident, said the resident required extensive assistance of two plus staff for a specific care need.

Interviews with two Registered Practical Nurses (RPN), Personal Support Worker (PSW) and Physiotherapy Assistant (PTA), showed that the identified resident no longer required the specific care, since returning from hospital, and an alternate care was provided.
The care plan was not revised when the identified resident returned from hospital, to include the resident's current care need.

Assistant Director of Care (ADOC) said the home's expectation would be that the care plan for the identified resident resident should reflect the actual care that was provided.
The plan of care for an identified resident did not ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

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 plan of care sets out clear directions to staff and others who provided direct care to the resident, specifically related to transfers and toileting, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System (CIS) report was submitted related to an incident where an identified resident sustained an injury while being transferred, with the assistance of one Personal Support Worker (PSW).

An interview with a Neighbourhood Coordinator, a review of internal investigative records, resident clinical records and an observation of the resident's room, showed that a specific transfer status for the identified resident was indicated however, this was not followed at the time of the incident.

During an interview, the Neighbourhood Coordinator said that the PSW did not follow the transfer logo and did not use safe transferring and positioning devices or techniques when assisting the resident, resulting in injury. [s. 36.]

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 staff used safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Findings/Faits saillants :

1. The home's Falls Prevention and Management Program did not, at a minimum, provide for strategies to reduce or mitigate falls for one resident.

The home's Fall Prevention & Management Policy, Tab04-33, directed "registered staff to assess each resident with any change in condition for potential risk for falls using The Falls Risk Assessment, to discuss acceptable levels of risk with input from the resident and/or POA and the interdisciplinary team and to develop and implement interventions based on the individual risk factors identified in the assessment. The policy further directed registered staff to document on the residents' plan of care, risk, goals and interventions for prevention and management of falls".

An identified resident sustained falls with injury. After the initial fall, the post fall assessment did not include consideration of additional fall prevention intervention strategies to reduce the recurrence of falls.

Both Assistant Directors of Care said that the care plan for the identified resident was not reviewed after the initial fall and that the resident's clinical record did not include discussion of fall prevention intervention strategies with the identified resident.
If fall prevention intervention strategies had been proposed to the identified resident and the resident refused, the refusal would be included in the resident's clinical record.
Both ADOC's said that the home's Falls Prevention and Management Program did not provide for strategies to reduce or mitigate falls for an identified resident, after the initial fall. [s. 49.]

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 the home's falls prevention and management program provided for strategies to reduce or mitigate falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee of the home ensured that proper actions were taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drug, including psychotropics

A review of an identified resident's clinical record showed there were five incidents of missing narcotics.
There was no internal incident report completed for four of the five incidents, the Power of Attorney (POA) and police were not notified of one incident and the Ministry of Health and Long Term Care (MOHLTC) was not notified for five of the five incidents, either through the after hours pager system or a Critical Incident System (CIS) report.

During an interview, the Director of Care (DOC), said all narcotic medication incidents should have been investigated, an incident report filed, MOHLTC contacted, updated the CIS, the police contacted and the resident's Power of Attorney (POA) should be notified at the beginning of the incident, during the investigation and followed up with the final results of the investigation.
[s. 134. (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 to ensure that the licensee of the home took proper actions in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drug, including psychotropics, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day of three incidents that caused an injury to three residents that resulted in a significant change in the residents' health condition and for which the residents were taken to a hospital.

A review of three Critical Incident System (CIS) reports showed three identified residents sustained injuries and were taken to hospital. The Ministry of Health and Long Term Care (MOHLTC) after-hours pager was not contacted. The Director was not notified, through a CIS report, until four to seven days after the incidents occurred.

During an interview the Director of Care (DOC) # 101 and Assistant Director of Care (ADOC) # 102 said the Director was not informed no later than one business day of three incidents that caused an injury to three residents that resulted in a significant change in the residents' health condition and for which the residents were taken to a hospital. [s. 107. (3) 4.]

Issued on this 5th day of July, 2017

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

Original report signed by the inspector.