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
Oct 11, 2017	2017_532590_0015	015877-17	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 at St.Clair
1800 Talbot Road WINDSOR ON 000 000

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

ALICIA MARLATT (590), ALISON FALKINGHAM (518), ANDREA DIMENNA (669)

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): July 24 - 27, 2017.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), the Director of Nursing (DON), two Assistant Directors of Nursing (ADON), the Director of Recreation, a Registered Dietitian (RD), three Registered Nurses (RN), five Registered Practical Nurses (RPN), eight Personal Support Workers (PSW), two Dietary Aides, the representatives of the Resident's and Family Council, three family members and 40+ residents.

During the course of the inspection, the inspector(s) observed infection prevention and control practices, all resident home areas, staff and resident interactions, recreational activities, medication administration, postings of required information and the provision of resident care. During the course of the inspection, the inspector(s) reviewed resident's clinical records, Family and Resident's Council meeting minutes and relevant policies and procedures related to inspection topics.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who is incontinent received an assessment that: Includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

This inspection was completed as a result of a Minimum Data Set (MDS) assessment related to an identified resident's decline in continence status in stage one of this Resident Quality Inspection (RQI).

When an identified resident was admitted to the home they were continent.

Review of this resident's clinical record outlined:
The admission MDS assessment stated the resident was continent.
The admission continence assessment stated the resident was continent.
The MDS assessment on a specified date stated the resident had a change in continence.

The most recent care plan for this resident included specific interventions related to incontinence.

Review of the home's policy Nursing-Continence Tab 04-29 with no revision date stated:
Procedure
1. Upon move in, each resident will have a continence assessment using the Resident Assessment Instrument (RAI) MDS tool in combination with a resident specific assessment. Villages using Point Click Care (PCC) will use the online assessment,

named continence. The RAI MDS assessment will include a seven day observation period. For residents who are incontinent, the voiding and bowel elimination record may be used to determine patterns over a two day period. The results of these assessments will be used by the interprofessional team to create a plan of action and individualized care plan.
2. Residents who require assistance with toileting, or with transfers onto the toilet using a sit to stand lift or pivot transfer will receive hygiene assistance and/or offered a washroom break regularly throughout the shift.
3. The resident will be offered cleaning supplies to cleanse after elimination. Residents who are unable to cleanse independently or need assistance will be provided with peri-care after elimination and with every hygiene change, utilizing cleansers that promote the natural ph balance to promote skin integrity.
8. The resident's continence will be reassessed annually and as needed using the continence assessment tool, with care plan update included.

This identified resident was observed on three separate occasions, ambulating around the nursing unit, neat, clean and well groomed with no evidence of incontinence.

In interviews with two PSW's, one RPN and a family member of this resident, they stated that the resident was continent when they were admitted to the nursing home and remained continent until a specified date, when they became incontinent.

In an interview with the ADOC and a RPN, they stated that a continence assessment should have been completed on the specified date, when the resident became incontinent. [s. 51. (2) (a)]

2. This inspection was completed as a result of a MDS assessment related to an identified resident's decline in continence status in stage one of this RQI.

When an identified resident was admitted to the home they were continent.

Review of this resident's clinical record showed the following:
The admission MDS assessment for the resident showed that the resident was continent.
The admission continence assessment showed that the resident had mixed incontinence.

The MDS assessment dated later than admission, showed that the resident was occasionally incontinent.

This resident's current care plan showed that the resident was usually continent.

Review of the home's policy Nursing-Continence Tab 04-29 with no revision date stated:
Procedure
1. Upon move in, each resident will have a continence assessment using the RAI MDS tool in combination with a resident specific assessment. Villages using PCC will use the online assessment, named continence. The RAI MDS assessment will include a seven day observation period. For residents who are incontinent, the voiding and bowel elimination record may be used to determine patterns over a two day period. The results of these assessments will be used by the interprofessional team to create a plan of action and individualized care plan.
8. The resident's continence will be reassessed annually and as needed using the continence assessment tool, with care plan update included.

Review of this resident's clinical record showed that there was no continence assessment completed to determine the change in this resident's continence status.

In an interview with the DOC, they shared that continence assessments are completed on admission and annually and when there is a change in the resident's condition. They shared that there had not been another continence assessment completed after the identified resident was admitted to reflect the change in continence status.

The licensee has failed to ensure that residents who are incontinent received an assessment that: Included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

The severity was determined to be a level two as there was minimal harm or potential for harm. The scope of this issue was identified as a pattern throughout the inspection. The home has a history of unrelated non-compliance. [s. 51. (2) (a)]

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 resident's who are incontinent receives an assessment that: Includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives 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 assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 assessment.

This inspection was conducted as a result of an observation of altered skin integrity on an identified resident during stage one of the RQI.

This resident was admitted to the long term care home on a specified date, with several diagnoses.

The resident developed a skin impairment and was observed on two separate occasions, with a treatment in place.

Review of this resident's clinical record stated:
On a specified date, the MDS assessment showed no skin issues present.
The most recent Skin Observation assessment showed no skin issues present.

The most recent care plan for this resident included specific interventions related to altered skin integrity.

Review of the home's policy Skin and wound care Program, Tab 04-78 stated:
Roles and Responsibilities of Team Members - Nursing (RN and RPN)
- Assesses altered skin integrity including skin breakdown, pressure injuries, skin tears and wounds weekly and documents within the assessment for pressure and stasis injuries
- Refers to the dietitian using the dietitian referral form for any and all altered skin integrity
- Notifies the interprofessional team and the wound care lead when the area has healed using whichever communication method is in use at the village (PCC villages can use an alert-there is no requirement to complete another referral)
Assessment
The registered team member will conduct an assessment and document that assessment:
- Within 24 hours of moving in
- Upon return from the hospital
- Following a leave of absence greater than 24 hours and quarterly within the MDS assessment
- Complete a skin assessment when there is a change in skin integrity and weekly thereafter until it is healed
- Complete the wound assessment of the areas reported and weekly thereafter

In interviews with a RN and a RPN, they stated that the registered staff member who

discovered and treated the area of altered skin integrity, would be responsible for completion of a computerized skin assessment.

In an interview with the GM, they reviewed the computerized record, noted there was an open skin assessment that had not been initiated and stated that it is their expectation that the registered staff member who discovered and treated the area of altered skin integrity would have completed a skin assessment.

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 assessment.

The severity was determined to be a level two as there was minimal harm or potential for harm. The scope of this issue was identified as isolated throughout the inspection. The home has a history of this area of legislation being issued in a Complaint inspection #2017_418615_0013 on July 12, 2017, as Compliance Order #001 due to be complied with on August 31, 2017. [s. 50. (2) (b) (i)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

This inspection was completed as a result of a MDS assessment in stage one of the the RQI related to pain.

Review of the MDS assessment on a specified date, showed that an identified resident was having mild pain daily to a specified site. The previous three MDS assessments completed on specified dates, all showed that the resident was not having pain.

Review of the home's policy titled "Pain Management Program" stated in the procedure section that:
"The registered team will:
1. Complete and document a pain assessment:
- on initiation of a pain medication or PRN analgesics
- on move in and returns from hospital
- quarterly - any level of pain should be assessed or with an MDS pain score of two or more or significant change of status
- when there are personal expressions exhibited by resident that may be an indicator for the onset of pain
- when there is a change in condition with pain onset
- with diagnosis of a painful disease
- when resident reports any pain or symptoms especially those of greater than 4 out of 10 on a severity scale for 24 to 48 hours
- with history of unexpressed pain - what has helped before - information from family/SDM
- when receiving pain medication for greater than 72 hours
- with distress related to personal expressions or facial grimacing
- when report from resident, family, team member volunteers that pain is present"

Review of this resident's pain assessments, showed that pain assessments were completed on three specified dates.

Review of this resident's pain medications showed the following:
- That the resident was started on an analgesics by mouth three times a day on a specified date
- That the resident was started on a stronger analgesic as needed on a later specified date
- That the resident was started on the stronger analgesic twice a day on a specified date
- That the resident was on a third analgesics for an identified time period

In an interview with two RPN's, they both shared that pain assessments are to be completed when a resident is started on a new pain medication, a pain medication is

stopped and when the dosage or frequency of pain medication changes.

In an interview with the GM, they shared that they expect the staff to follow the home's policy related to pain and that pain assessments were not completed with the initiation of new pain medications for this resident.

The severity was determined to be a level two as there was minimal harm or potential for harm. The scope of this issue was identified as isolated throughout the inspection. The home has a history of this area of legislation being issued in a Complaint inspection #2017_418615_0013 on July 12, 2017, as Compliance Order #002 due to be complied with on August 31, 2017. [s. 52. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they sought the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

This inspection protocol was completed as a mandatory part of this RQI.

The Family Council meeting minutes for their last three meetings in April, May and June 2017, were reviewed and the minutes did not document anything about the satisfaction survey being reviewed by the council.

In an interview with the Director of Recreation, they shared that the home did not seek the advice of the Family Council to assist in developing their satisfaction surveys. They stated that they had contacted the President of the Family Council, who shared that they could not recall reviewing the survey prior to the survey being distributed. The President recalled hearing about the results of the 2016, survey in their February 2017, meeting that the GM attended.

In an interview with the DOC, they shared that the home uses a third party for their satisfaction survey's and did not recall speaking with the Family Council about the development of the survey.

The licensee failed to ensure that the Family Council was provided the opportunity to review the satisfaction survey prior to the survey being distributed.

The severity was determined to be a level one as there was minimum risk to the resident's. The scope of this issue was identified as an isolated incident. The home has a history of unrelated non-compliance. [s. 85. (3)]

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Issued on this 10th day of January, 2018

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

Original report signed by the inspector.