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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 12, 2019	2019_533115_0005	002461-18, 004339-18, 005190-18, 009200-18, 009602-18, 009755-18, 010779-18, 011705-18, 014136-18, 014610-18, 018105-18, 019255-18, 021722-18, 025204-18, 025617-18, 027623-18, 031607-18, 033785-18, 001207-19	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 N9H 0E3

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

TERRI DALY (115), ALICIA MARLATT (590), AMBERLY COWPERTHWAITE (435)

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): February 11-15 and 19-21, 2019

Inspector Christy Legouffe #730 and inspector Ayesha Sarathy #741 were on site February 11-15, 2019.

The following Critical Incident inspections were conducted:
Related to falls prevention:
Critical Incident Log #002461-18 / 3046-000009-18
Critical Incident Log #010779-18 / 3046-000034-18
Critical Incident Log #011705-18 / 3046-000038-18
Critical Incident Log #014610-18 / 3046-000044-18
Critical Incident Log #021722-18 / 3046-000054-18
Critical Incident Log #033785-18 / 3046-000082-18

Related to alleged resident to resident abuse:
Critical Incident Log #004339-18 / 3046-000022-17
Critical Incident Log #014136-18 / 3046-000043-18
Critical Incident Log #019255-18 / 3046-000050-18
Critical Incident Log #025204-18 / 3046-000063-18
Critical Incident Log #025617-18 / 3046-000065-18
Critical Incident Log #031607-18 / 3046-000077-18
Critical Incident Log #001207-19 / 3046-000007-19

Related to alleged staff to resident abuse:
Critical Incident Log #009200-18 / 3046-000030-18

Related to missing narcotics:
Critical Incident Log #009755-18 / 3046-000033-18

Related to alleged inappropriate care:
Critical Incident Log #027623-18 / 3046-000069-18

Related to improper transfer:
Critical Incident Log #005190-18 / 3046-000016-18

Related to alleged visitor to resident abuse:
Critical Incident Log #009602-18 / 3046-000031-18

Related to unknown injury:
Critical Incident Log #018105-18 / 3046-000047-18

During the course of the inspection, the inspector(s) spoke with the Director of Nursing, Assistant Director(s) of Nursing, a Registered Nurse, Registered Practical Nurses, Personal Support Workers, Neighbourhood Coordinators, Resident Assessment Instrument Coordinator, Personal Support Worker, and a Housekeeping Aide.

The inspector(s) also made observations of residents, resident and staff interactions and care and services. Reviewed relevant policies and procedures, as well as clinical records and plans of care for identified residents.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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	Légende 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 free from neglect by the licensee or staff in the home.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, reporting an incident of improper/incompetent treatment of a resident that resulted in harm or risk to a resident. The home shared that the resident was experiencing a medical condition which had started the day before. The leadership team, along with the nurse practitioner and physician, were not made aware of the change in status until the next day, and at that time the resident was sent to the hospital. The home started an investigation, and reported that the investigation results were pending.

Prior to the residents' change in status, the resident was able to ambulate and transfer using a specific transfer status. This was written in a progress note by the physician, and also the residents' care plan at the time.

Review of the resident's progress notes over two days before the resident was sent to the hospital, showed no documentation related to this residents' condition and symptoms. The physician wrote a note on a specific date, documenting that they were not made aware of the resident's condition the day before. They completed an assessment of the resident and ordered the resident to be sent to the hospital for further assessment.

Review of the resident's Point Of Care (POC) record, the documentation/communication system used by staff in the home, showed that on a certain date the resident was able to be transferred twice that day with a specific transfer status. The next day, the resident was transferred twice and required a different transfer status to physically assist the resident, showing an increase in physical assistance needed. POC was the documentation system that Personal Support Workers (PSW) used to communicate with registered staff.

Review of the alerts made in POC by the PSW's on a specific date, was completed. PSW's documented alerts to the registered staff three times on the day shift on that date. The first alert documented that staff observed the resident in pain and nurse follow up

was needed. The second alert entered documented that the resident expressed extreme pain in a certain area, was put back to bed after breakfast and had difficulty transferring. The third alert documented that the resident had exhibited repetitive health complaints.

All three of the alerts were cleared by RPN #123. In an interview with RPN #108, they said that the PSW's made alerts in the POC system for the registered staff, when things need to be addressed by the nursing staff. The nursing staff were supposed to address the alert, and clear the alert when the issue was resolved. If the alert could not be addressed, the nurse working was to report this to the oncoming shift for follow up, or ask for help from another unit to address the issue. The alerts were not to be cleared until they had been addressed.

The shift reports for this resident's neighbourhood on three consecutive days, were reviewed. On the first day, there was nothing abnormal reported about the resident. On the second day, day shift reported that the resident had refused lunch, that they were not standing, had increased pain to specific areas and an analgesic rub was applied, and that the resident was verbally expressive. The evening shift reported that the resident was in bed all shift and that the analgesic rub was applied to one of the areas. The night shift reported that the resident complained of pain in a specific area and analgesics were given. On the third day, shift report sheets, the day shift had documented that analgesic rub was applied to specific areas and the resident was laying down all shift, had specific symptoms and was being sent to the hospital. In an interview with RPN #108, they said that the shift report sheets were used by nurses and PSW's to communicate any nursing and care concerns, and any follow up which needed to be completed for any resident.

The inspector reviewed the homes' internal investigation notes. There was a note documenting an interview between management and RPN #123 who was working days on a specific date. This RPN explained that they had assisted with a transfer of this resident, and they had been the third person needed to complete the transfer safely. The RPN said that they were aware of the PSW's concerns and alerts in POC and had completed an assessment of the resident. This RPN acknowledged not using a pen light to assess each pupils reaction or size and had assessed range of motion on the residents one side only. The RPN acknowledged being aware of the residents pain and had applied the analgesic rub, but had not actually assessed the residents pain. The RPN said that they noticed the resident leaning to one side during the breakfast meal. This RPN indicated that they had assessed the resident after breakfast, however upon review of completed assessments in the residents clinical record for three consecutive days, there were no documented assessments of this resident.

In an interview with Director of Nursing (DON) #100, they said that they had completed an investigation of the incident. They had found that RPN #123 had been aware of the resident's change in condition on a specific date, as it was reported to them by PSW staff. The nurse had failed to assess the resident at that time. It was not until after breakfast when the nurse assessed the resident. The nurse did not document the assessments, nor report the assessment findings or change in condition to the physician, or oncoming staff for follow up and monitoring. This nurse had cleared the three alerts made by the PSW's without addressing the concerns. The DON said that this nurse was terminated and reported to the College of Nurses of Ontario in relation to their performance. The DON indicated that this type of practice was neglectful. [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 were protected from abuse by anyone and free from neglect by the licensee or staff in the home, 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, reporting an incident of possible improper/incompetent treatment of a resident that resulted in harm or risk to a resident.

A resident was assessed by the Kinesiology team as a specific lift and transfer status. They documented that the team members were aware to move up in transfer status as

needed, as the direct care staff reported to Kinesiology that the resident was having increased difficulty with transfers.

The resident's care plan was reviewed. The care plan at the time of the incident had a focus on transfer safety and informed staff that the resident was a specific transfer status. It also informed staff that an alternate transferring mechanism would also be appropriate if required.

The resident's Minimum Data Set (MDS) was reviewed for transfer status. The most recent MDS assessment completed a few months prior to the incident documented that the resident required a specific transfer status to transfer the resident safely.

A falls incident report was reviewed and documented that a contributing factor to the resident's incident was unsafe practice. The report further documented that a Personal Support Worker (PSW) approached the Registered Practical Nurse (RPN) on duty and reported to them that the resident was on the floor and needed assistance. They reported to the RPN that they had attempted to transfer the resident by themselves, and that they had lowered the resident to the floor.

Review of the resident's progress notes showed documentation about the incident. The RPN who received the report from the PSW, documented that the PSW reported to them that they attempted transferring the resident themselves, and could not complete the transfer and lowered the resident to the floor. The same RPN and PSW had just completed a transfer of this resident a few minutes before this incident. The RPN documented in quotes that they told the PSW that the resident was a specific transfer status and that they were not supposed to transfer this resident by themselves.

In an interview with RPN #117 who responded to the incident, they shared that the PSW knew that the resident was a specific transfer status at the time of the incident. This RPN had assisted this same PSW with a transfer of the resident earlier in the shift. The PSW came to them shortly after the first transfer, to report that the resident needed assistance and was on the floor. The PSW reported that they attempted to transfer the resident by themselves, but the resident started to fall and they could not hold them up and guided them to the floor. The RPN completed an assessment of the resident and notified the charge nurse of the incident immediately.

In an interview with RN #118 who also responded to the incident, they shared that they had received the report from the RPN that an improper transfer occurred on the

neighbourhood and that a resident was injured. The RN spoke with the PSW who admitted to them to have attempted an improper transfer. The RN sent the PSW home pending investigation, and immediately notified the management and the MOHLTC to the events which occurred.

Review of the homes' policy titled 'Manual Transfers', policy number: Tab 04-66 C, showed a procedure section which outlined the following: "All team members will review transfer logos prior to transferring the resident. Team members are required to provide assistance at minimum as indicated by the transfer logo located within the resident's room. Failing to adhere to the minimum transfer status as determined by the transfer logo will result in discipline as per Schlegel Villages' Discipline Policy."

During an interview ADON #105, shared that the PSW had attempted an unsafe transfer which resulted in injuries to a resident. The staff member was re-educated and disciplined. [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 use 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. 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. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident,

or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was 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) Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's

health condition.

A) A Critical Incident was reported to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, it identified a resident who had a change in condition and was sent to hospital for assessment in relation to an incident. This report was submitted to the MOHLTC under the category "Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status".

A progress note for this resident on a specific date date described an incident in which the resident sustained injury and was sent to hospital.

During an interview with Associate Director of Nursing (ADON) #105, they stated that the resident sustained an injury from an incident on a specific date, when asked when they first became aware of this incident they stated they were first made aware the day after. When asked when the MOHLTC was first made aware of this incident, they stated a specific date which was seven days after the incident.

B) A Critical Incident was reported to the Ministry of Health and Long-Term Care on a specific date, it identified a resident who had a change in condition and was sent to hospital for assessment. This report was submitted to the MOHLTC under the category "Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status".

A progress note on a certain date, stated in part, that the resident had been found on the floor outside of their room. It continued to state that the resident was complaining of pain and the resident was transferred to the hospital. A subsequent progress note stated, in part, that the resident's Power of Attorney (POA) called the home to inform them that the resident was admitted to hospital.

During an interview with Director of Nursing (DON) #100, they stated that the incident had occurred on a specific date. DON #100 stated that the resident required surgical intervention and interventions were put in place. When asked what the home considered a significant change in condition, DON #100 stated that this would be coded in the Minimum Data Set (MDS) and a change to the resident's plan of care would be required. When asked when they became aware of the incident, they stated a date that was three days after the incident. When asked when the MOHLTC was first made aware of the incident, they stated this same date.

The licensee had failed to ensure that the Director was informed of these incidents that caused an injury to a resident for which the resident was taken to a hospital and that resulted in significant change in the resident's health condition. [s. 107. (3) 4.]

2. The licensee had failed to ensure that they informed the Director of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. 2. A description of the individuals involved in the incident, including, i. names of any residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident. 3. Actions taken in response to the incident, including, i. what care was given or action taken as a result of the incident, and by whom, ii. whether a physician or registered nurse in the extended class was contacted, iii. what other authorities were contacted about the incident, if any, iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and v. the outcome or current status of the individual or individuals who were involved in the incident. 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence. 5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

During this Critical Incident System (CIS) inspection, there were 19 CIS reports that were inspected. Of the 19 inspected CIS reports there were five that were either not completed fully, or were not updated after investigations were completed.

A CIS report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date. This report was missing the name of a staff member that was involved in the incident, and the report documented that an investigation was ongoing. The report was amended, however the amendment did not include the missing staff name or the results of the investigation. There were no further amendments to the report at the time of this inspection in February 2019. This report had been completed by ADON #105.

A CIS report was submitted to the MOHLTC on a specific date. This report documented that an investigation was ongoing, but had not been amended after the investigation to include the results at the time of this inspection February 2019. This report had been completed by ADON #105.

A CIS report was submitted to the MOHLTC on a specific date. This report documented that follow up with a team member was pending. The report had not been amended to include the follow up completed with the staff member at the time of this inspection, February 2019. This report had been completed by ADON #105.

A CIS report was submitted to the MOHLTC on a specific date. This report was missing the last name of a resident that was involved in the incident being reported. The report had not been amended to include the residents' full name at the time of this inspection in February 2019. This report had been completed by ADON #116.

A CIS report was submitted to the MOHLTC on a specific date. This report documented that two residents were involved in an altercation. One of the involved residents was sent to the hospital with injury. This report had not been amended to include the outcome of the residents hospital visit, or if any changes in care were required. This report had been completed by a previous ADON who no longer worked at the home.

In an interview with ADON #105, they shared that the reports they completed had not been amended and should have been.

In an interview with DON #100, they acknowledged that numerous CIS reports had not been completed or amended as required by the Act or Regulations. The home initiated an action plan to rectify their reporting performance at this inspection. [s. 107. (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 the appropriate reporting of critical incidents, to be implemented voluntarily.

Issued on this 25th day of March, 2019

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

Original report signed by the inspector.