Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Jul 23, 2019	2019_750539_0010	000913-19, 002244-19, 004049-19	Complaint

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 University Gates
250 Laurelwood Drive WATERLOO ON N2J 0E2

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

VALERIE GOLDRUP (539)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 17-21, 2019

The following intakes were completed in this Complaint inspection:
Log #002244-19/ IL-63804-CW and Log #004049-19/ IL-64460-CW/ IL-64461-CW, complaints regarding resident care.

Log #000913-19/ Follow up to CO #001 from inspection #2018_787640_0025, s. 8(1) of O. Reg. 79/10, following the home's policy regarding the implementation of head injury routine.

During the course of the inspection the inspector toured the home and observed resident care, services and activities. Clinical records and plans of care for identified residents were reviewed. Also, relevant documents were reviewed including but not limited to the home's documentation and procedures as related to the inspection.

During the course of the inspection, the inspector(s) spoke with the General Manager, Director of Nursing and Palliative Care (DON), Assistant Directors of Care (ADOC), a Behavioural Support Ontario (BSO) Registered Practical Nurse, a Behavioural Support Ontario (BSO), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and their families.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2018_787640_0025	539

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. 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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's written plan of care set out clear directions to staff and others who provided direct care to the resident.

A complaint was made to the Ministry of Long-Term Care (MOLTC) on a specified date, concerning the needs of a resident.

The resident's plan of care stated the resident needed a specific type of assistance.

Progress notes and a memo detailed the resident's preference for assistance.

Registered staff reviewed the plan of care, acknowledging that the information in the plan of care where staff go to find out about a resident's care needs did not match the

progress notes and a memo.

The licensee failed to ensure that the resident's written plan of care set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the resident's plan of care was provided as specified in the plan.

A complaint was made to the MOLTC on a specified date, concerning the care provided to a resident.

On a specified date, registered staff were instructed to assess the resident and provide a specified treatment prior to providing care. There was no documentation of the provided care during a specified month.

The resident was referred to the physician for an additional specified treatment to be provided prior to care. The resident did not receive the specified treatment until two weeks later.

The licensee failed to ensure that the care set out in the resident's plan of care was provided as specified in the plan. [s. 6. (7)]

3. The licensee failed to ensure that the resident's plan of care was revised when the resident's care needs changed.

A complaint was received by the MOLTC on a specified date, concerning the needs of a resident.

The resident's plan of care stated the resident needed a specific type of assistance.

Progress notes stated the resident required a different amount of assistance.

Registered staff stated that the resident's level of assistance had changed and the plan of care had not been updated to address the changed ability of the resident.

The licensee failed to ensure that the resident's plan of care was revised when their care needs changed. [s. 6. (10) (b)]

4. The licensee failed to ensure that the resident's plan of care was revised when there was a change in their condition.

A complaint was received by the MOLTC on a specified date, concerning the care needs of a resident.

On a specified date, the resident underwent a procedure.

The instructions provided after the procedure gave direction for follow-up treatment.

Registered staff could not locate the treatment provided as per the home's treatment documentation practices.

The licensee failed to ensure that the resident's plan of care was revised when there was a change in their condition. [s. 6. (10) (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 there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident, is provided as specified in the plan of care, and is reviewed and revised when the resident's care needs change or there is a change in a resident's condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a registered dietitian who was a member of the staff of the home, completed a nutritional assessment on two residents when there was a significant change in their status.

a) On a specified date, a resident's nutritional ability changed.

The home's policy, entitled Nutritional Care; Dietary Needs, stated to immediately make a Registered Dietitian (RD) referral after observing a change in the resident's assessed needs.

No referral was made by registered staff in regards to the resident's nutritional ability change, until an additional request for follow-up was made by family.

b) On a specified date, a resident's nutritional ability changed.

A RD referral was made but the RD did not assess the resident nor did they make any changes to their plan of care until a second request for assessment was made by family.

The home's policy, entitled, Nutritional Care: Dietary Needs, stated registered staff, the registered dietitian and or the physician should complete a thorough assessment.

Registered staff said they would refer to the RD for any change.

The licensee failed to ensure that a registered dietitian who was a member of the staff of the home, completed a nutritional assessment on the two residents when there was a significant change in the resident's nutritional ability. [s. 26. (4) (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 a registered dietitian who is a member of the staff of the home, completes a nutritional assessment when there is a significant change in a resident's status, to be implemented voluntarily.

Issued on this 24th day of July, 2019

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

Original report signed by the inspector.