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
Feb 22, 2019	2019_650565_0001	015183-17, 017386-17, 020572-17, 004279-18	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

Erin Mills Lodge Nursing Home
2132 Dundas Street West MISSISSAUGA ON L5K 2K7

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

MATTHEW CHIU (565), JUDITH HART (513)

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): January 8, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, and 24, 2019.

During the course of the inspection, the Follow-Up intake log #017386-17 related to compliance with manufacturers' instructions was inspected.

During the course of the inspection, the following Critical Incident System (CIS) intake logs were inspected:
- #015183-17, #004279-18 related to prevention of abuse and improper care of resident, and
- #020572-17 related to resident injury resulting in significant change in health status.

During the course of the inspection, a finding of non-compliance was identified under LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) related to resident #018 and issued under concurrent complaint inspection #2019_634513_0002.

During the course of the inspection, the inspector(s) spoke with the General Manager, Director of Nursing Care (DNC), Assistant Director of Nursing Care (ADNC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Maintenance Staff (MS), Registered Dietitian (RD), Physiotherapist (PT), Residents, and Family Members.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

- **1 WN(s)**
- **1 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. 23.	CO #001	2017_449619_0018	565

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. (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).

Findings/Faits saillants :

1. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of a CIS report revealed that on an identified date, resident #002 was found on the floor in their room and sustained an identified significant injury. The CIS report further revealed the falls prevention interventions in place for the resident, but it did not mention a particular intervention being used at that time.

Record review for resident #002 revealed that on the identified date and time, the resident had a fall and it was unwitnessed. The records stated RPN #104 found resident #002 on the floor, the resident was assessed and sent to the hospital on the same day. The records did not indicate the above mentioned fall intervention was being used at the time of the fall.

Further record review of resident #002's clinical record revealed the resident had mild physical and cognitive impairments. The plan of care stated the resident required a specified level of transfer assistance and had a specified risk for falls. The resident's falls prevention interventions included the use of the above mentioned identified intervention.

Interview with PSW #103 revealed they recalled the above mentioned incident, but they did not recall the details of the incident.

Interview with RPN #104 revealed on the identified date and time period while performing a specified care to a co-resident, they found resident #002 on the floor. RPN #104 did not recall if the above mentioned fall intervention was in place at the time they fell. When RPN #104 reviewed the resident's plan of care together with the inspector, the RPN stated the resident should have been using the identified fall intervention when they fell but they were not.

Interview with the DNC indicated the falls prevention care that were in place for resident #002, at the time of the above mentioned fall, included the interventions stated in the CIS report. The DNC did not recall if staff, at that time, mentioned that the above mentioned identified fall intervention was given to resident #002. The DNC confirmed that it should have been provided to the resident as specified in the plan, but it was not. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 25th day of February, 2019

[redacted]

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

Original report signed by the inspector.