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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 26, 2018	2018_580568_0003	023806-17, 023807-17, 023809-17, 023810-17, 023812-17, 023813-17, 023814-17	Follow up

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 of Riverside Glen
60 Woodlawn Road East GUELPH ON N1H 8M8

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

DOROTHY GINTHER (568), JANETM EVANS (659), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 8, 9, 13, 14, 15, 16, 20, 21, 22, 23, 26, 27, 28, 2018 and March 1, 2018.

The following intakes were completed as part of this follow-up inspection:
Critical Incident #2915-000077-17 / log #028326-17 and #2915-000078-17 / log #029102-17 related to a fall with an injury
Complaint IL-54723-LO / log #029595-17 related to multiple care concerns

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager, Director or Nursing Care, Assistant Directors of Nursing Care, Assistant Food Services Manager, Registered Dietitians, Neighbourhood Coordinators, RAI / Quality Improvement Coordinators, Registered Nurses, Registered Practical Nurses, Personal Care Aides, families and residents.

The inspectors also conducted observations of residents, the provision of care, and interactions between staff / residents; as well as medication administration, drug destruction and storage areas. Relevant policies and procedures, investigation notes specific to the complaints and critical incidents inspected as part of the follow-ups were reviewed, in addition to the clinical records and plans of care for the identified residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Skin and Wound Care

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

- **2 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. 136. (3)	CO #007	2017_263524_0009	659
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2017_263524_0009	568
O.Reg 79/10 s. 50. (2)	CO #006	2017_263524_0009	568
O.Reg 79/10 s. 52. (2)	CO #004	2017_263524_0009	568
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2017_263524_0009	568
O.Reg 79/10 s. 71. (3)	CO #005	2017_263524_0009	568
O.Reg 79/10 s. 8. (1)	CO #003	2017_263524_0009	568

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).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was 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 was specifically designed for assessment of incontinence where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

During an interview with a substitute decision maker (SDM) for an identified resident, they told the Inspector that they had seen a decline with respect to the resident's continence and they were now wearing a different continence product.

Interviews with two Personal Care Aides (PCA) and record review identified that the specified resident was incontinent of urine to some degree.

The home's policy titled "Continence" Tab 04-29 created January 16, 2013 and last reviewed on June 6, 2017, stated under the "Procedure" that the resident's continence would be reassessed annually and PRN using the Continence Assessment Tool, with care plan update included.

On a specified date, the RAI / Quality Improvement (QI) Coordinator said that staff on the

neighbourhood where the resident lived reported that the resident's continence had declined. The RAI / QI Coordinator said that in light of the change in continence, they should have been reassessed using the Continence Assessment tool on Point Click Care (PCC) and based on this assessment the plan of care updated.

The licensee failed to ensure that a resident who was 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 was specifically designed for the assessment of incontinence. [s. 51. (2) (a)]

2. The licensee has failed to ensure that the resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

On a specified date, a SDM for an identified resident told the Inspector that they had seen a decline in the resident's level of continence. The SDM said that they had been visiting the resident for a couple of hours and staff had not come in to ask if the resident needed to use the washroom.

During observations on a specified date over a three and a half hour period, the resident was not seen going to the washroom and staff were not observed toileting the resident.

Interviews with two PCA's and review of the resident's clinical record identified that the specified resident was incontinent of urine to some degree and required staff assistance for toileting.

The licensee failed to ensure that a resident, who was unable to toilet themselves independently some or all of the time, received the assistance from staff to manage and maintain their continence. [s. 51. (2) (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 a) each resident who is incontinent receives an assessed 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 the assessment of incontinence 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; c) each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with all applicable requirements under the Act.

The home's policy titled "Skin and Wound Care Program" Tab 04-78 published on November 6, 2016, stated under the section of "Roles and Responsibilities of Team Members - Nursing (RN and RPN)" that they refer to the dietitian using the dietitian

referral form, areas of altered skin integrity including skin breakdown, pressure injuries, skin tears and wounds.

O. Reg. 79/10, s. 50 (2) (b) (iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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. For the purposes of this section, O. Reg. 79/10, s. 50 (3) defines "altered skin integrity" as the potential or actual disruption of epidermal or dermal tissue.

Review of a specified resident's clinical record showed a Skin Observation Tool note and Weekly Skin Observation note which stated that the resident had altered skin integrity where the skin was not broken. There was no evidence that a referral had been sent to the Registered Dietitian.

During an interview with a Registered Practical Nurse (RPN) they told the Inspector that for altered skin integrity where there was an opening in the skin they would send an electronic referral to the Registered Dietitian (RD). For altered skin integrity where the skin was not broken, they would not refer to the RD. The RPN stated that for the identified resident, because the skin was not broken they did not send a referral to the RD.

In an interview with the RAI / QI Coordinator and Skin/Wound Care Lead they said that in terms of altered skin integrity it was the home's expectation that a referral be sent to the RD for any areas where there was a break in the skin i.e. skin tear, laceration, stage II or greater pressure ulcer. In the case of altered skin integrity where the skin was not broken, the nursing staff monitor and reassess weekly, but their policy does not direct them to refer to the RD unless there was a specific concern. When the RAI / Quality Improvement Coordinator was shown the definition of altered skin integrity outlined in the legislation, they agreed that altered skin integrity where the skin was not broken would fall within it and their policy did not comply with the legislation.

The licensee failed to ensure that the home's Skin and Wound Care Program policy complied with the legislation. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 16th day of April, 2018

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

Original report signed by the inspector.