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
Jun 12, 2018	2018_634513_0006	000463-18, 005764-18, 006386-18, 006687-18	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 of Erin Meadows
2930 Erin Centre Boulevard MISSISSAUGA ON L5M 7M4

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

JUDITH HART (513)

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): May 1, 2, 3, 4, 7, 8, 9. 10, 11, 14, 15, 16, 17, 18, 22, 23 and 24, 2018.

The following complaint (CO) logs were inspected concurrently with the corresponding Critical Incident System (CIS) logs: CO Intake #006386 and CIS Intake # 000463-18, for the Prevention of Abuse and Neglect and CO Intake #005764 -18 and CIS Intake #006687-18 for Falls and Plan of Care regarding bed rails.

During the course of the inspection, the inspector(s) spoke with the associate director of care (DOC), registered nurse (RN), registered practical nurse (RPN), personal care assistant (PCA), registered dietitian (RD), physiotherapist (PT), physiotherapist assistant, neighbourhood coordinator, physician, residents and family members.

During the course of the inspection, the inspector: observed resident care, staff to resident interactions and resident to resident interactions; and reviewed resident health records, staff schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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. 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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is (b) complied with.

The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is (b) complied with.

A review of the policy, regarding falls, Tab 04-33 and approved August 14, 2017, states to initiate identified assessments for all unwitnessed falls and witnessed falls that have resulted in possible injury unless indicated in the plan of care.

A review of intake # 005764-18 revealed that resident #001's SDM and POA lodged a complaint with the MOHLTC INFOLine call IL-56533-TO on the 18th day of a specific month in 2018, with regard to the management of resident #001's health conditions, specifically regarding an incident related to falls.

A review of the progress notes on 14th day of a specific month in 2018, revealed that resident #001 had an incident related to a fall and was found at 2130h in a specific position. The resident was assessed with no injury detected. Vital signs were taken and specific assessments were initiated. A review of the identified assessments on the 14th day of the identified month in 2018, revealed specific assessments: #3 at 2300 hours (h); #4 at 2330h; #5 on the 15th day of the identified month 2018, at 0030h; #6 at 0130h; and #7 at 0230h, were observed not completed as part of the scheduled assessments.

An interview with RPN #118 revealed that when a resident has a fall the specific assessments previously identified, including vital sign assessments, are to be completed as per protocol in the resident's electronic record. The specific assessments as indicated on the 14th and 15th day of the identified month above were not documented as completed as part of the scheduled assessments.

An interview with the Associate Director of Care (ADOC) #108 revealed the expectation of the home for a resident who has had a fall is that all components of the assessment were to be completed. In this instance, not all scheduled assessments were completed as per home expectation and therefore the home's policy for prevention and management of a fall was not complied with.

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any falls prevention policy, the licensee is required to ensure that the falls prevention policy is (b) complied with, to be implemented voluntarily.

WN #2: 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

A review of intake # 005764-18 revealed that resident #001's SDM and POA lodged a complaint to the MOHLTC INFOLine call IL-56533-TO on the 18th day of a specific month in 2018, with regard to the management of resident #001's health conditions on a

specified date, specifically related to the POA's request regarding resident care at bedtime.

The current written plan of care dated the 15th day of a specific month in 2018, stated, the resident should retire at a specified time and staff should complete a specified task. In case the resident is awake and restless, the team member should bring the resident to the nursing station in the wheelchair and inform the nurse.

A review of the progress notes on the 14th day of the specific month in 2018, revealed resident #001 was found to have fallen. The resident was assessed without pain or injury. Frequent monitoring began for seven days.

An interview with PSW #133 revealed on the evening shift of the 14th day noted above, resident #001 was assisted by PSW #133 and another PSW at a specified time. Neither PSW, including #133, completed the specified task as per the plan of care, as both PSWs left the resident's room together. PSW #133 stated, they now understand they are to complete the specified task as per the plan of care and that the plan of care was not followed.

An interview with RPN #118 revealed the plan of care identified that the resident was to receive specific resident care before retiring.

An interview with the ADOC #108 confirmed that since the PSWs did not complete the specific care, the plan of care was not followed as specified in the written plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care for medications was not documented as set out in the plan of care.

a) A review of the physician's digiorder for resident #001 revealed on the 19th day of an identified month in 2018, a specific medication was prescribed.

A review of the medication administration record (MAR) for the 23rd day of a specific month in 2018, revealed the identified medication was prescribed beginning on the 19th day of a specific month in 2018, at 1641h. Medications received by the resident are documented on the MAR with the initials of the registered staff who have administered the medication to the resident or with rational, coded as a number, for not administering the medication. The medication referenced previously was not signed on the MAR on the

19th day of the specific month in 2018, at 1700h, and on the 23rd day of the same month in 2018, at 1700h; and on the 24th day of the same month in 2018, at 0800h and 1700h, with the RPN's initials indicating documentation of the medication received, or not, by resident #001.

An interview with RPN #119 did not reveal rationale as to why the medication was not documented and signed off on the MAR as administered for the above dates.

An interview with the ADOC #108, confirmed the medication referenced above was not documented and signed off on the MAR for the identified dates and times as per the expectation of the home.

b) A review of the physician's digiorder, dated on the 23rd day of a specific month in 2017, at 0920h, revealed a telephone prescription for resident #001 for one dose of an identified medication, then one dose three days later. Medications received by the resident are documented on the MAR with the initials of the registered staff who have administered the medication to the resident or with rational for not administering the medication. The medication noted above was not signed off on the MAR for 23rd day of the specific month in 2017, at 1200h, with the RPN's initials indicating documentation of the medication received, or not, by resident #001.

A review of the progress notes on the 23rd day of a specific month in 2017, at 1143h state, "CVH med processed; informed MD Lindner and order confirmed; Pharmacy send medication;" Resident's daughter will come and assist resident to take medications as resident refused morning medications four times.

A review of the MAR for the 23rd day of the identified month in 2017, revealed the specified drug for administration at 1200h was not signed off as administered or with rational for not administering the medication.

An interview with the ADOC #108, confirmed the specific medication previously identified on the 23rd day of the identified month in 2017, at 1200h, was not documented and signed off on the MAR as per the expectation of the home.

c) A review of the physician's digiorder revealed on the 19th day of a specific month 2017, a specific medication was prescribed.

A review of the MAR revealed the identified medication began on the 20th day of a

specific month in 2017, and was signed off as administered at 0800h and 1700h. On the 21st day of this month in 2017, the medication was not signed off as administered at the scheduled times of 0800h and 1700h, however the notation in the progress notes identified resident#001 had refused the 1700h medications, accepted them at 1900h.

An interview with RPN #118 revealed the medication for 0800h on the 21st day of the identified month in 2017, cited above, was not signed on the MAR as administered or with rational for not administering the medication. An interview with RPN #119 revealed the medication for 1700h on the date cited above was not signed on the MAR as administered or with rational for not administering the medication.

An interview with the ADOC #108 confirmed the 0800h and 1700h administration of the identified medication on the 21st day of the specified month in 2017, was not signed on the MAR as administered or with rational for not administering the medication. [s. 6. (9) 1.]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care was revised because care set out in the plan had not been effective and different approaches had not been considered in the revision of the plan of care.

A review of intake # 005764-18 revealed that resident #001's SDM lodged a complaint to the MOHLTC INFOLine call IL-56533-TO dated the 18th day of a specific month 2018, with regard to the management of resident #001's health conditions on an identified month in 2018, specifically related to resident #001's fall strategies identified on the 21st, 22nd, and 31st of a specific month in 2017.

A review of the written plan of care, from the 1st day of an identified month to the 31st day of the following month in 2018, identified the resident was at risk for falls. The written plan of care for this timeline did not identify any revisions to the interventions and strategies for resident #001's falls, which included incidents of falls on specified dates in a specific month in 2017.

A review of the progress notes revealed the following:
• On the 21st day of an identified month in 2017, at 1115h resident #001 was observed to be ambulating without an assistive device, entered a co-residents room, experienced a fall, which was witnessed and received a small alteration in skin integrity.
• On the 22nd day of the same month in 2017, at 0630h resident #001 was observed to have mild alteration in skin integrity to a specified area; the resident denied pain; cause

was unknown.
• On the 31st day of the same month in 2017, at 2255h resident #001 was observed with an alteration in skin integrity to a specific location with unknown cause when RPN #134 was assisting the resident into bed.

An interview with RPN #134 identified resident #001 was at risk for falls and as the RPN assisted resident #001 to bed on the specified date above, noted an area of altered skin integrity to a specified location from an unknown cause.

An interview with RPN #118 identified resident #001 was at a high risk for falls as per assessment on the 27th day of the prior month in 2017. This RPN confirmed there were no new interventions or changes to the written plan of care for the identified month in 2017, related to falls.

An interview with ADOC #108 revealed the expectation of the home for a resident who was at risk for falls was to identify alternative strategies to prevent falls. In this instance, on review of resident #001's written plan of care for the specified incidents dated the 21st, 22nd, and 31st of a specific month in 2017, the ADOC confirmed no new fall strategies were explored during this time. The ADOC further confirmed that the falls strategy was not effective and in this instance the plan of care was not reviewed or revised on a specified month in 2017, following the above incidents. [s. 6. (11) (b)]

WN #3: 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 are not neglected by staff.

A) Under O. Regulation 79/10, s. 5 for the purpose of the definition "neglect" means, the failure to provide a resident with the treatment, care, services or assistance required for

health, safety or wellbeing, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A review of intake # 006386-18, dated the 29th day of a specified month in 2018, revealed resident #001's SDM and POA lodged a complaint to the Ministry of Health and Long Term Care (MOHLTC) IL#54796 dated the 2nd day of a specified month 2018, with regard to the management of resident #001's health conditions, specifically related to an identified medical condition.

A review of the progress notes from the 10th day to the 20th day of a specified month in 2017, revealed resident #001 was more sedated, so sedating medications were reduced or discontinued; was drinking less at breakfast, but increased fluid intake during the day; and the POA was concerned about the lack of mobility, so the resident would start on a restorative walking program. On the 10th day of the specified month in 2017, a specific test was prescribed to rule out a medical condition. On the 12th day of this month in 2017, two days later, a sample was collected, the result communicated to the physician, and a sample sent for further specific testing.

A review of the physician's digiorder on the 10th day of a specific month in 2017, for resident #001, revealed the following sequence:
• On the 10th day of this month in 2017, the physician prescribed a specific test to be completed and reported to the physician;
• On the 12th day of this month in 2017, the specified sample was sent to the lab for analysis;
• On the 16th day of this month in 2017, the result was printed by the lab;
• On the 19th day of this month in 2017, the result was received by home and dated;
• On the 19th day of this month in 2017, the physician prescribed a specific medication; and
• On the 20th day of this month in 2017, the specific medication was administered to resident #001.

An interview with RPN #118 revealed the process for obtaining and testing the specific sample would take a couple of days; the home would get results in a couple of days or would call the center in two to three days and then call the physician with the results; when the result comes it identifies the response and the physician uses this information to prescribe medications. The timeline for collection of this specific specimen was reviewed as noted above with RPN #118 who stated, the delay was not acceptable.

An interview with ADOC #018 revealed a delay with the processing and communications regarding the identified specific specimen and confirmed, in this instance, there was a time delay. In addition, after reading the definition of neglect, ADOC #018 confirmed that in this instance the delay to provide service to resident #001 from specimen collection to obtaining the result and administration of the prescription met the definition of neglect. [s. 19. (1)]

2. The licensee has failed to ensure that residents are not neglected by staff.

B) Under O. Regulation 79/10, s. 5 for the purpose of the definition "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 review of intake # 005764-18 revealed that resident #001's SDM lodged a complaint to the MOHLTC INFOLine call IL-56533-TO dated the 18th day of a specific month in 2018, with regard to the management of resident #001's health conditions for a specified month in 2018, specifically related to the POA's request for placement of assistive devices.

A review of progress notes identified the following:
• On the 14th day of the specified month in 2018, resident #001 was observed to be engaging in alterations of mobility, was located to a common area and slept.
• On the 15th day of this month in 2018, the POA requested assistive devices be placed for safety. The referral to the Kinesiologist was sent. Three staff were aware of the request: RPNs #118 and #119 and neighbourhood coordinator #130.
• On the 21st day of this month in 2018, the resident was found to have experienced a fall. No injury was identified.
• On the 22nd day of this month in 2018, the Kinesiologist completed an assessment and stated resident #001 may benefit from an assistive device.
• On the 24th day of this month in 2018, at 0150hours (h) the resident was observed to be asleep in bed. At 0200h staff were alerted by an identified alarm and found resident #001 had fallen and an alteration in skin integrity to an identified location was observed. The resident was assessed for fracture, neural assessment completed, head injury routine (HIR) protocol completed, ice applied to the affected area and medications administered including an analgesic for discomfort.
• On the 24th day of this month in 2018, a general maintenance referral request #6485198 was made for the instillation of the requested assistive devices, which were installed immediately.

An interview with RPN # revealed the assistive devices for resident #001 were requested by the family on the 14th day of a specific month in 2018. The process was to assess the resident's need for the assistive devices, obtain permission from the POA, call maintenance and have the devices installed. The devices were ordered and installed on the 24th day of the identified month in 2018. RPN #118 stated the assistive devices were not implemented in a timely manner.

An interview with ADOC #108 confirmed the family requested the assistive devices be applied; the application of the assistive devices was delayed; the resident had two falls resulting in alterations in skin integrity; the staff was disciplined for the delay in the application of the assistive devices; and the assistive devices were implemented on the 24th day of the identified month 2018. The ADOC read the definition for neglect and confirmed that in this instance there was a delay to provide the specified service to resident #001 that met the definition of neglect. [s. 19. (1)]

Issued on this 15th day of June, 2018

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

Original report signed by the inspector.