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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 16, 2019	2018_769646_0022	010684-18, 018440-18, 030558-18	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

The Village of Erin Meadows
2930 Erin Centre Boulevard MISSISSAUGA ON L5M 7M4

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

IVY LAM (646), DEREGE GEDA (645)

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): November 27, 28, 29, 30; December 3, 4, 5, 6, and 7, 2018.

During the course of the inspection, the following Critical Incident system (CIS) report intakes were inspected:

Log #018440-18 (CIS #2881-000017-18) related to a fracture of unknown cause, and Log #030558-18 (CIS #2881-000029-18) related to alleged staff to resident neglect.

During the course of the inspection, the following follow-up intake was completed:

Log #010684-18 related to continence and bowel management.

PLEASE NOTE: A Voluntary Plan of Action related to LTCHA, 2007, c.8, s. 6 (4) (a), identified in a concurrent inspection #2018_526645_0017 (Log # 022140-18) was issued in this report.

A Voluntary Plan of Action related to LTCHA,2007, O. Reg. 79/10, s. 36, was identified in this inspection and has been issued in inspection report #2018_526645_0017, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager, Assistant Director of Nursing Care (ADNC), Neighborhood Coordinator (NC), RAI-MDS Coordinator, Physiotherapist (PT), Kinesiologist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, and Family Members.

During the course of this inspection, the inspector conducted a tour of the home, residents' home areas, residents' care, staff to resident interactions, and reviewed residents' health care records, home's records, staffing schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention

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. 51. (2)	CO #001	2018_420643_0006	645

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 had failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) related to concerns about resident #011's peri-care and oral care.

Review of the plan of care on PointClickCare (PCC) on an identified date for resident #011's oral and dental hygiene showed that the resident required an identified level of assistance to brush their teeth in the morning, and to ensure proper care for the resident's dentures. Observations and interviews with resident #011, personal support workers (PSWs), and registered staff showed that the care was provided as per the resident's care plan, and staff were providing rinsing of mouth after an identified meal time. Findings of non-compliance were not identified in this inspection related to the resident's oral care.

Review of resident #011's plan of care on PCC on the identified date showed the resident required an identified level of assistance for toileting. The resident was identified

to be incontinent and used an identified type of incontinence product, and required team members to check for incontinence at identified times. This inspection did not identify findings of non-compliance related to continence care and bowel management for resident #011.

However, findings were identified for the resident's transfer as part of the resident's continence care during review of the resident's health records and observations of the resident. Review of the same care plan under the transferring focus showed the resident required an identified level of assistance when using an identified type of transfer equipment.

Review of resident #011's Physiotherapy Assessments on two identified dates both indicated
- Transfers: same type of transfer equipment as per the resident's above mentioned care plan
- Chair/Bed to Chair: A second identified type of transfer equipment for residents who required a higher level of assistance.

Review of the Kinesiology Program for Active Living assessments for transfer assessment only, on two identified dates showed:
- Transfer status: same type of transfer equipment as per resident's above mentioned care plan
- Resident needs an identified level of assistance when using the first identified type of transfer equipment. If unable to weight bear or follow instructions, use the second identified type of transfer equipment.

Observation of resident #011 in the resident's room on an identified date, showed that resident #011 was transferred by PSWs #100 and #101 using the second identified type of transfer equipment. Observation of resident #011 on another identified date in the resident's room showed the resident was transferred by PSWs #100 and another PSW using the second identified type of transfer equipment.

Observation of PSW #103 on the second identified date mentioned above showed the inspector that the staff use the first identified type of transfer equipment for resident #011's transfer. PSW #103 stated in an interview that this is what is used for the resident based on the transfer logo in the resident's room and it is in the resident's care plan. Review of resident #011's Individual Care Service Plan (ICSP) report on the PSW tablet showed: TRANSFER - Resident requires extensive assistance by an identified number of

team members using the first identified type transfer equipment.

In an interview with PSW #100 who worked on another shift, the PSW stated that they are not able to toilet resident using a first identified type of transfer equipment because it is not safe.

Interview with Registered Practical Nurse (RPN) #104 stated that the PSWs had not told the RPN that they were always using the second identified type of transfer equipment, but the RPN had seen the PSWs use the second identified type of transfer equipment with resident #011 regularly for an identified number of months and it is not something new for the resident as the resident is very tired.

The RPN reviewed the physiotherapist (PT)'s assessment on an identified date which stated to use the first identified type of transfer equipment for sit to stand, and chair/bed to chair is the second identified type of transfer equipment. The RPN further stated that the registered staff should make a referral to the PT or kinesiologist if the resident was always using the second type of transfer equipment on their shift. The RPN reviewed the Kinesiology assessment on an identified date and stated that the assessment said to use the first identified type of transfer equipment for transfer but if resident was not able to weight bear or follow instructions, then to use the second identified type of transfer equipment. RPN #104 further stated that the information from the assessments were not included in the resident's written care plan on PCC, and it was not clear for the registered staff what should be used for resident #011. RPN #104 also stated that the PSWs cannot see the assessments and only see what is on the ICSP or the transfer logo, and would not see instructions about using the second identified type of transfer equipment.

Interview with the Physiotherapist (PT), they stated that it is hard to sit resident #011 up in the morning, and from bed to chair, it is best for staff to use the second identified type transfer of equipment. The PT stated their assessment also stated to use the first identified type of transfer equipment, which was meant for when the resident is toileted. The PT stated they have not been informed that the staff were only using the second identified type of transfer equipment for resident #011 during day shift. The PT stated that the resident is more alert in the evening, and the evening staff may use the first type of transfer equipment. The PT also noted the kinesiologist's assessment for the resident to use the first identified type of transfer equipment, but if the resident was unable to weight bear or follow instructions, to use the second identified type of transfer equipment. The PT further stated that the instructions from the PT and kinesiologist's assessments

regarding when to use the second identified type of transfer equipment were not included in the resident's written care plan.

Assistant Director of Nursing Care (ADNC) #112, Neighbourhood coordinator (NC) #106 and the PT stated in separate interviews that there was a gap in collaboration in the team's assessment of resident #011's transfer needs, and the assessments were not integrated and consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee had failed ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

This inspection was initiated to inspect on a critical incident submitted to the MOHLTC on an identified date related to an incident that causes an injury to resident #012, for which the resident was taken to hospital and which resulted in a significant change in the resident's health. Resident #012 was found on an identified date with facial grimacing when RPN touched an identified area of the resident's body. The resident was assessed by the Nurse Practitioner (NP) and transferred to hospital for investigation, was diagnosed with an identified injury the following day, and returned to the home six days after being diagnosed with the identified injury.

1) Review of resident #012's care plan updated prior to the incident indicated that the resident used an identified transfer equipment for transfers with assistance by an identified number of team members, and that this revision was made by Resident Assessment Instrument – Minimum Data Set (RAI-MDS) Coordinator #117.

Review of the resident's last transfer assessment on an identified date by the kinesiologist on the Kinesiology Program for Active Living Assessment prior to the incident, indicated the resident used a manual transfer by an identified number of team members.

Interview with the RAI-MDS coordinator indicated that they had changed the care plan for resident #012 during the Resident Assessment Protocol (RAP) at an identified time period, as the PSWs had informed them that the resident had frequent falls, and the PSWs had been using the identified transfer equipment for the resident. The RAI-MDS coordinator stated it is their usual process to ask the PSWs and the registered staff regarding residents' care during the RAP review process, but had not reviewed the

kinesiologist's assessment. The RAI-MDS coordinator further indicated the registered staff are able to change and update the care plan if the residents' care needs change.

Interview with the kinesiologist and the PT indicated that they were not involved when the resident's care plan was changed on the abovementioned identified date to indicate the resident used the abovementioned identified transfer equipment for transfer. The kinesiologist and PT further indicated that they were informed the resident was using the abovementioned identified transfer equipment only after the incident when the resident returned from the hospital with an injury to an identified part of the resident's body.

The kinesiologist indicated that they were not notified when the resident's transfer needs changed from manual transfer to the abovementioned identified transfer equipment, and would expect a referral from the team so they could assess and provide insight to the team on the resident's transfer needs.

Interview with ADNC #111 indicated that there was a gap in the collaboration amongst the team members regarding the assessment of resident #012's transfer status.

2) Review of resident #012's Kinesiology Program For Active Living (PAL) Assessment on an identified date showed that a new strategy of a specified falls prevention intervention had been recommended, nursing will document for three shifts before implementing, and that the care plan had been reviewed.

Review of resident #012's care plan showed that the specified falls prevention intervention was included in the resident's written plan of care under Environmental Modifications to reduce fall risk on the abovementioned date.

Review of the home's Falling Leaf program list of residents with active falls and/or a high falls risk posted at the nursing station, showed a number of identified support strategies for resident #012, but did not include the abovementioned specified falls prevention intervention for the resident.

Review of the resident's progress notes did not show any documentation regarding use of the abovementioned specified falls prevention intervention for resident #012 for four months prior to the time of the inspection.

Observations of resident #012's room on two identified dates showed that the resident

was not using specified falls prevention interventions.

Interviews with PSW #119 and RPN #107 indicated resident #012 was at high risk for falls and had been provided an identified number of falls prevention interventions. PSW #119 and RPN #017 further stated that the resident did not use the abovementioned specified falls prevention interventions, and have never seen it used in the past.

Interview with the kinesiologist indicated that resident #012 was at high risk for falls, and the specified falls prevention interventions were a part of the resident's falls care plan strategy, and that this intervention was included in the resident's written care plan. They indicated that they were not aware that resident #012 did not currently use the specified falls prevention interventions, and that their recommendation for specified falls prevention intervention use had not been implemented. The kinesiologist further indicated that there was a gap in the implementation of resident #012's falls prevention intervention recommendations, as there were no documentation of the specified falls prevention interventions from the staff and no communication to the kinesiologist as to whether the specified falls prevention interventions would continue or not.

Interview with ADNC #111 indicated that there was a gap in the communication and collaboration between the team regarding the implementation of resident #012's falls prevention interventions. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

This inspection was initiated for resident #013, as part of the sample expansion when a finding of non-compliance was identified with safe transferring for resident #012.

Review of the resident's current care plan showed that resident #013 required an identified level of assistance by an identified number of team members with transfers. Review of the resident's transfer logo in the room indicated the same number of team members as the care plan for transfers. Review of the falling leaf program information for resident #013 indicated the resident was to be transferred by a different number of team members.

Observation of resident #013 on an identified date showed that the resident was transferred by PSW #114 and another PSW.

Interview with PSW #114 indicated that resident #013 required is transferred with an identified number of team members, and staff transferred the resident according to the transfer logo in the resident's room. The PSW further indicated that there is also a falling leaf program which provided transfer instructions for PSWs and registered staff. Upon review of the falling leaf program transfer direction for resident #013, the PSW stated that the falling leaf program direction needed to be revised as the resident's care needs is different from what was indicated on the resident's transfer logo and in the care plan.

Interview with RPN #113 stated resident #013 required transfer by an identified number of team members and had been provided this level of assistance for an identified period of time. The RPN stated the falling leaf program was a document that staff refer to for resident's transfer care, and that the directions for resident #013's transfer needed to be updated on the falling leaf program sheet.

Interview with the kinesiologist and ADNC #112 acknowledged the falling leaf program, as part of the resident's plan of care, and that it should have been changed when the resident's care needs changed for transfer to reflect the resident's current needs. [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 that:
- staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, and
- the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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*

Issued on this 30th day of January, 2019

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

Original report signed by the inspector.