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 8, 2019	2019_659189_0005	005744-19, 010285-19	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 of Erin Meadows
2930 Erin Centre Boulevard MISSISSAUGA ON L5M 7M4

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

NICOLE RANGER (189)

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 10, 11, 12, 13, 14, 17, 18, 19, 20, 25, 26, 2019

The following intakes were inspected:
Log #005744-19 related to skin and wound care, continence care and hospitalization and change in condition
Log #010285-19 related to personal support services

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), Director of Nursing Care (DNC), Assistant Director of Nursing Care (ADNC), Director of Recreation, Behavioual Support Ontario (BSO)Lead, Neighbourhood Coordinator, registered staff, personal support workers and residents.

During the course of the inspection the inspector observed staff to resident interactions, conducted observations of the residents, reviewed residents' health records, reviewed the home's investigation notes, relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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	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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint related to alteration of skin integrity for resident #001. The complainant reported that during a prescribed treatment, RPN #103 provided the care in a rough manner, resulting in the resident sustaining an identified injury.

Interview with RPN #103 revealed that resident #001's family member requested the prescribed treatment. RPN # 103 reported that during the application of the treatment, the resident sustained a specified injury. RPN #103 reported that they were not aware of the details of the residents' prescribed treatment and the residents' condition. RPN #001 acknowledged that they were not kept aware of resident #001 plan of care. [s. 6. (8)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

The MOHLTC received a complaint related to resident #002's injury to an identified body area. The complainant reports that the resident had no recent falls , requires total care for assistance and that the home was unable to identify how the resident sustained the injury.

A review of resident #002's plan of care indicated that the resident required assistance with bed mobility and personal care.

Record review of resident #002's Point of Care (POC) report indicated no documentation was completed the night before the incident.

Interview with PSW #122, who worked the night before the incident, revealed that they had documented on the night shift of the care provided to the resident, however review with the Director of Nursing Care (DNC) confirmed that the documentation was not completed, and that the home's expectation is that the PSWs are expected to complete the POC documentation on every shift. [s. 6. (9) 1.]

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 staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it; and that the provision of the care set out in the plan of care are documented, to be implemented voluntarily.

WN #2: 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,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who requires continence care products had sufficient changes to remain clean, dry and comfortable.

The MOHLTC received a complaint related to continence care for resident #001. According to the complainant, resident #001 was left in their incontinent product for 12 hours and was not changed.

A review of the plan of care indicated that resident #001 is incontinent and is to be checked and changed twice per shift.

Interview with PSW #105 revealed that they were assigned to provide care to the resident on the identified date. PSW #105 reported that they changed the resident incontinent product at 0650 hours, and that they left the unit at 1000 hours to attend a meeting. PSW #105 reported that PSW #104 was assigned to cover while they attended the meeting.

Interview with PSW #104 revealed that they were assigned to cover for PSW #105 while the PSW was attending a meeting. PSW #104 reported that they did not change the resident until 1330 hours when resident #001's family member requested the resident to be changed. PSW #104 reported that the resident was incontinent and acknowledge that the resident did not receive sufficient changed to remain clean, dry and comfortable. [s. 51. (2) (g)]

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 resident who requires continence care products had sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the equipment, supplies, devices and positioning aids are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

The MOHLTC received a complaint related to alteration of skin integrity for resident #001. The complainant reported that during a prescribed treatment, RPN #103 provided the care in a rough manner, resulting in the resident sustaining an identified injury.

A review of the progress notes revealed that on an identified date, the physician ordered a specified treatment. Interview with RPN #126 revealed that the order was received to apply the treatment, however the nurse checked the storage and other neighbourhoods and there was no supply available. RPN #126 reported that they applied a different treatment than was prescribed.

Interview with the Assistant Director of Nursing Care (ADNC) #108 revealed that the process for ordering care supplies are completed on a monthly basis after consultation with the ET nurse and a review of the current care supplies in the home's storage. The ADNC acknowledge that the care supplies for resident #001 was not available. [s. 50. (2) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident is dealt with as follows: The complainant shall be investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint.

The MOHLTC received a complaint related to resident #002's injury to an identified body area. The complainant reports that the resident had no recent falls , requires total care for assistance and that the home was unable to identify how the resident sustained the injury.

A review of the progress notes and interview with RPN #125 revealed that on a specified date, RPN #125 received a verbal complainant from the resident's family member regarding how the resident sustained the injury. The family member was then directed to speak to the Neighbourhood Coordinator #102 related to the concerns.

Interview with the Neighbourhood Coordinator #102 acknowledged that a complaint was received from the family member on the specified date, however they went on vacation and did not complete the investigation until their return. A response was provided to the family weeks later.

Interview with the Director of Nursing Care (DNC) confirmed that a response was not provided to the family within 10 business days of the receipt of the complaint. [s. 101. (1)]

Issued on this 9th day of July, 2019

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

Original report signed by the inspector.