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
Nov 27, 2019	2019_659189_0017	012489-19, 015911-19, 015966-19, 016756-19	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), SLAVICA VUCKO (210)

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): November 4, 6 ,7, 8, 12, 2019.

During the course of the inspection, the following Complaint intake logs were inspected:
Log #016756-19, #015966-19 related to prevention of abuse and neglect, personal support services.
Log #015911-19 related to prevention of abuse and neglect.
Log #012489-19 related to personal support services.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Director of Nursing Care (DNC), Director of Environmental Services, Assistant Director of Nursing Care (ADNC), Kinesiologist, Occupational Therapist (OT), Physiotherapist (PT), Food Service Supervisor (FSS), Neighborhood Coordinator (NC), RAI MDS coordinator, Behavioural Support Ontario Lead (BSOL), Behavioural Support Ontario personal support worker (BSO PSW), registered nurse (RN), registered practical nurse (RPN), personal support worker (PSW), agency personal support worker, residents, and family members.

During the course of the inspection the inspectors observed staff to resident interactions, the provision of care, reviewed residents' health records, staff training records, home's investigation notes, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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)**

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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident who demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments, and interventions, and that the resident's responses to interventions were documented.

The Ministry of Long Term Care (MLTC) received a complaint related to responsive behaviours demonstrated by resident #005 towards resident #004.

Resident #005 was admitted to the home on an identified date. The admission package received from the Local Health Integration Network (LHIN) included documents which identified that the resident had a history of responsive behaviour, however did not demonstrate this behaviour at the time of admission to the home.

In the first week following resident #005's admission to the home, there were three incidents documenting responsive behaviours. When interviewed, the Assistant Director of Nursing Care (ADNC) #126 and Neighborhood Coordinator (NC) #111 stated that no additional interventions for resident #005 had been initiated as a result of the incidents, but that they had conducted a huddle with the staff to discuss monitoring of resident #005. ADNC #126 also stated that staff had been informed of resident #005's history of responsive behaviours.

Interview with NC #111 who is the Behavioural Support Ontario (BSO) Lead, reported that the resident was to be followed by the BSO team upon admission, however the home was unable to provide any documentation to verify that this had occurred.

Review of the home's policy titled "Personal Expression Program", undated, instructs staff that in response to situations where a residents actions or reactions puts other residents at risk, the registered team member, with the support from his/her leadership team and Personal Expression Resource Team (PERT) team will begin to determine the level of risk of the situation.

The home failed to take actions, including following the above mentioned policy or implementing any assessments or interventions in response to resident #005's responsive behaviours. [s. 53. (4) (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 for each resident demonstrating responsive behaviours , actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the right of every resident not to be neglected by the licensee or staff was fully respected and promoted.

The Ministry of Long Term Care (MLTC) received a complaint reporting that staff failed to respond to resident #006's call for assistance.

Interview with the complainant indicated that on an identified date, they visited resident #006. They passed by the nursing station where RN #107 was documenting on the computer. According to the complainant they noticed that the call bell light in front of resident #006's door was on, and when they entered the room they found the resident in the washroom, on the floor. According to the complainant, they picked up the resident and sat them back on the toilet. The complainant then left resident #006's room looking for a staff member. They found RN #107 in the Physio room. The complainant requested help and RN #107 attended to the resident immediately.

The resident complained of pain to an identified area and was sent to hospital for further

assessment. The discharge report from hospital indicated the resident did not sustain injury.

Interview with PSW #104 identified that resident #006 was able to toilet themselves and to use the call bell, and that they are assisted with toileting after meals PSW #104 indicated that on the identified date, they offered to assist the resident with toileting after the meal but the resident refused, so PSW #104 went to tend to other residents.

Interviews with PSW #106 and #105 indicated that when this incident occurred they were both working with other residents and neither could recall if resident #006's call bell was activated.

Interview with RN #107 indicated they were at the nursing station when the family member of resident #006 arrived. RN #107 acknowledged that they were aware of a call bell ringing at this time, but they had not identified where it was coming from and had not attended to it.

Interview with the Director of Nursing Care (DNC) indicated that the home's expectation if the PSWs are busy, registered staff are expected to respond to call bells.

The DNC acknowledged that the staff's failure to respond to resident #006's call bell on this occasion, constituted a failure of resident #006's right not to be neglected. [s. 3. (1) 3.]

Issued on this 4th day of December, 2019

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

Original report signed by the inspector.