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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 4, 2014	2014_349590_0028	L-001440-14	Resident Quality Inspection

Licensee/Titulaire de permis

R-B-J SCHLEGEL HOLDINGS INC.
325 Max Becker Drive, Ste. 201, KITCHENER, ON, N2E-4H5

Long-Term Care Home/Foyer de soins de longue durée

THE VILLAGE OF ASPEN LAKE
9855 McHugh Street, WINDSOR, ON, N8P-0A6

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

ALICIA MARLATT (590), ALISON FALKINGHAM (518), CAROLEE MILLINER (144), PATRICIA VENTURA (517)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 27, 28, 29 & 30, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Assistant Director of Nursing, the Director of Food Services, the Assistant Director of Food Services, the Registered Dietitian, Dietary Aides, the President of the Residents Council, the President of the Family Council, the Director of Environmental Services, a Laundry Aide, a Neighbourhood Coordinator, a Ward Clerk, a RAI Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers and 40+ Residents.

During the course of the inspection, the inspector(s) toured all resident home areas, observed dining services, medication rooms, medication administration, the provision of resident care, staff/resident interactions, recreational activities, postings of required information, and reviewed Resident and Family Council meeting minutes relevant to inspection, resident clinical records relevant to the inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee did not ensure that the written record is kept up to date at all times for every resident of a long term care home.

a) A resident was noted to have a catheter.
b) The written plan of care identifies urine output is to be documented on each shift. Review of the Urine Output Record for the month of October, 2014, reveals urine output has not been documented on every shift.
c) The written plan of care identifies a schedule of when the resident's catheter bag is to be changed. Documentation confirmed the resident's catheter bag was not changed as outlined in the schedule for October.
d) The written plan of care includes a schedule outlining when this residents catheter care should be completed. There is no documentation to confirm the catheter care was completed as outlined in the schedule during the month of October, 2014.
e) The plan of care identifies the resident is to be showered twice a week. There is no documentation in the clinical record confirming the resident was provided a shower twice a week during the month of October, 2014.
f) One Registered Practical Nurse confirmed there was no documentation in the resident's clinical record related to items listed above in b), c), d), and e).
g) The Director of Nursing confirmed it is the expectation that the items listed above in b), c), d) and e), are to be documented in the resident's clinical record and that the home has not ensured the resident's written record was kept up to date. [s. 231. (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 the written record is kept up to date at all times for every resident of the long term care home., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receives fingernail care, including the cutting of fingernails.

a) During an interview with a resident Inspector #144 observed that the resident's fingernails were long.
b) The resident confirmed to the Inspector that they did not like their fingernails this long and that staff are supposed to trim them during baths.
c) One registered staff shared that front line staff are responsible for trimming residents fingernails during their baths & confirmed after review of the resident flow sheet, that this residents fingernails were not trimmed during their bath.
d) One nursing manager confirmed that it is the responsibility of front line staff to notify registered personnel of the need for particular residents to have their nails trimmed with specific diagnosis'. [s. 35. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies that is secure and locked.

a) A physician's ordered prescription [redacted] was observed on the night stand in a residents room.
b) One registered staff confirmed there was not a physician's order for the medication to be left at the bedside and that the prescription bottle had been left in the room by staff. The registered staff further confirmed that all prescription medications are to be stored in the locked medication room or medication cart.
c) One nursing manager confirmed the home's protocol for physician ordered medications is that the medication will be stored in the locked medication room and or locked medication cart. [s. 129. (1) (a)]

Issued on this 4th day of November, 2014

[redacted]

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