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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 21, 2015	2015_415190_0028	026236-15	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 ASPEN LAKE
9855 McHugh Street WINDSOR ON N8P 0A6

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

SANDRA FYSH (190)

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): October 6, & 7, 2015

This inspection was related to a complaint regarding resident care and infection control practices.

During the course of the inspection, the inspector(s) spoke with the General Manager, Acting Director of Nursing Care, Acting Assistant Director of Nursing Care, RAI (Resident Assessment Instrument) Coordinator, Recreation Aide, Registered Nurses, Registered Practical Nurse, Personal Support Workers and Resident.

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

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

An interview conducted with the Registered Nurse on the unit, indicated initially that the most current plan of care for Resident #001 was located on the written chart. The Registered Nurse later returned to the unit and provided a written plan of care stating that the most current plan of care is located on the computer.

Interviews with two Personal Support Workers on the unit revealed that they would look on the written chart for the most current plan of care because they do not have access to the plan of care on the computer.

The written plan of care does not provide direction to the staff for the following areas:

a) The plan of care noted that specific care interventions were required. No direction was provided on the plan of care for staff regarding the type of interventions required.

b) The ambulation section indicates that the resident was to walk to the dining room, however resident has not been walking to the dining room.

c) The recreation section indicates that the resident was to be encouraged to participate in recreational activities; resident is to be assisted to and from the music programs; resident is to be assisted to and from the bingo program and will be assisted to the arts and craft program on the neighbourhood.

d) The written plan of care does not provide direction to staff regarding meals or the type of supervision required for these meals.

e) The written plan of care indicates that the resident was to bathe in the tub twice a week, but Personal Support Workers on the unit state resident has been taking a shower recently.

The Director of Nursing Care (DNC) and the Assistant Director of Nursing Care (ADNC)

confirmed that the written plan of care did not provide clear direction to staff regarding the care of this resident and the changes that have been put in place. [s. 6. (1) (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 with ensuring the plan of care provides clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident has had an interdisciplinary assessment with respect to the resident's skin condition, including altered skin integrity.

Resident #001 has exhibited altered skin integrity. The plan of care did not identify specific details related to the altered skin integrity.

The plan of care was not based on an interdisciplinary assessment to provide direction to staff regarding specific direction for treatment or care.

Several different treatments were prescribed and applied. Skin assessments were not completed.

The DNC and the ADNC confirmed that the plan of care did not include interdisciplinary assessments related to the altered skin integrity. [s. 26. (3) 15.]

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 with ensuring that the plan of care is based on an interdisciplinary assessment of the resident's skin condition, including altered skin integrity and foot conditions., to be implemented voluntarily.

WN #3: 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.

Observation revealed Resident #001 had not received nail care.

A review of the personal care flowsheets for Resident #001 reveals that no nail care was provided during the twice weekly bath for the previous two months. It was confirmed with two Personal Support Workers on the unit, that they asked the Registered Staff to provide the nail care.

The Registered Staff on the unit confirmed that they have not provided fingernail care to the resident and that it should have been provided. [s. 35. (2)]

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 with ensuring that each resident of the home receives fingernail care, including the cutting of fingernails., to be implemented voluntarily.

Issued on this 21st day of October, 2015

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

Original report signed by the inspector.