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
Feb 2, 2016	2016_349590_0001	017611-15	Resident Quality Inspection

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

ALICIA MARLATT (590), ALISON FALKINGHAM (518), TERRI DALY (115)

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): January 4, 5, 6, 7, 8, 11, 12, 13, 14,15, 21 & 25, 2016.

The following Critical Incidents were inspected during this RQI:

Log #022022-15/CIS #3037-000052-15
Log #027621-15/CIS #3037-000060-15
Log #029111-15/CIS #3037-000062-15 & 3037-000067-15
Log #032980-15/CIS #3037-000072-15
Log #001374-16/CIS #3037-000070-15
Log #021989-15/CIS #3037-000048-15
Log #022923-15/CIS #3037-000051-15
Log #001504-16/CIS #3037-000002-16
Log #001638-16/CIS #3037-000071-15
Log #029979-15/CIS #3037-000069-15 - Was completed as an inquiry.
Log #018439-15/CIS #3037-000043-15 - Was completed as an inquiry.

A Follow-up inspection Log #036037-15 was also conducted during this RQI.

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Nursing Care (DNC), the Assistant Director of Nursing Care, the Director of Environmental Services, three Resident Assessment Instrument/Quality Improvement (RAI-QI) Nurses, one Registered Nurse (RN), eight Registered Practical Nurses (RPN), 21 Personal Care Aides (PCA's), two Dietary Aides, one Cook, one Recreation Aide, one Housekeeper, one Administrative Coordinator, one Private Care Nurse, the Resident's Council President, four family members and more than 40 Residents.

During the course of the inspection, the inspector(s) observed dining services, medication rooms and administration, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practises and posting of required information.

During the course of the inspection, the inspector(s) reviewed resident clinical records, relevant policies and procedures, relevant meeting minutes and records related to continuous maintenance in the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
9 WN(s)
8 VPC(s)
1 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2015_415190_0039	115

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. 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 received fingernail care, including the cutting of fingernails.

Resident #043 was observed during stage 1 of this RQI by inspector #518. The resident's fingernails were observed to be long and digging into their palms; there were red marks in their palms indicating the nails were in fact applying pressure into their palms.

Review of resident #043's progress notes revealed that they had an infection in one their nails in 2015, turning one of the nails black and was described as fungus in the progress note.

Review of resident #043's care plan revealed they are dependent on staff members to complete all aspects of their care, including fingernail trimming.

Review of resident #043's hygiene and grooming records over a two month period, indicated fingernail care was provided by the PCA's on only seven days.

The homes policy titled "Spa (Shower, Tub Bath, Sponge Bath)" last revised on January 8, 2015, policy number: 04-06 was reviewed. The policy indicated that residents will be provided a bath, shower or bed bath at a minimum of twice a week. The policy also indicated in the procedure section 13. that "After bathing is completed, provide nail care to feet and hands."

Interview with resident #043 revealed that fingernail care was not always completed by staff and that their hands can hurt sometimes from the fingernails digging into their palms.

Interview with PCA #133 revealed that fingernail care was completed by the PCA's on bath days and was documented on the residents Personal Care Observation and Monitoring Form.

RPN #116 confirmed that resident #043's fingernail care had not been completed on spa days according to the home's policy. [s. 35. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be properly sheltered, fed, clothed and cared for in a manner consistent with their needs was respected and promoted.

Resident #002 had areas of skin impairment which had dressings intact.

Resident #002 was observed several times during stage one of this RQI in which the intact dressings were exposed.
On a specified day, resident #002 was observed with nothing in place that covered the intact dressings.

RPN #120 confirmed that this resident should have the intact dressings covered.
RPN #120 and the General Manager #121 confirmed the resident did not have anything covering the dressings.
General Manager #121 confirmed the expectation was that all residents have the right to be cared for in a manner consistent with his or her needs. [s. 3. (1) 4.]

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's right to be properly sheltered, fed, clothed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #3: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During stage 1 of this RQI inspector #518 observed resident #043's hands to be contracted and emitting a foul odour. Their fingernails were observed to be digging into their palms as well, marking their hands.

Resident #043 had a care plan which indicated that the resident was to have a specific intervention in place to prevent skin breakdown. The resident was observed by inspector #518 to not have the specific intervention in place. The resident was again, observed by inspector #590 to not have the specific intervention in place.

Review of the Treatment Administration Record (TAR) for a specified time period, revealed the following:

The specific intervention was in place on 19 of the 30 days in one month.
The specific intervention was in place on 6 of the 31 days in one month.
The specific intervention was in place on 8 of the 12 days in the month thus far.

Inspector reviewed the TAR with RPN #116 and she confirmed that the specific intervention was not in place daily according to the TAR. She confirmed that if there was no signature beside the treatment she could not verify that the treatment was provided. She did confirm that the treatment outlined in the plan of care was not provided to resident #043. [s. 6. (7)]

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 care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Resident #053 had a fall and required hospitalization two days later.

The homes policy titled "Fall Prevention & Management" policy number: 04-33 and last revised on January 2013 was reviewed. The "Post - Fall Management" section 6. indicated that "The resident will be assessed each shift for 24 hours after the fall by the Registered Team Member who is on the Neighbourhood. A progress note will be completed X3 shifts."

Review of resident #053's progress notes revealed that there had been no progress note entry about the fall until two days after the fall when the resident was hospitalized.

Interviews with PCA #118, RPN #144 and a RAI/QI Coordinator #131 revealed they were aware of documentation requirements for appropriate post fall follow up.

Resident #053 had fallen again and there was no progress note to indicate the resident had been monitored on the afternoon and night shift after the fall.

The DNC confirmed the homes expectation was that the home's policies were followed. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Resident #054 had a fall which resulted in an injury for this resident.

The homes policy titled "Fall Prevention & Management" policy number: 04-33 and last revised on January 2013 was reviewed. The "Post - Fall Management" section 6. indicated that "The resident will be assessed each shift for 24 hours after the fall by the Registered Team Member who is on the Neighbourhood. A progress note will be completed X3 shifts."

Review of resident #054's progress notes revealed that there was no progress note to indicate the resident was monitored on the day and afternoon shift after the fall.

Interviews with PCA #118, RPN #144 and a RAI/QI Coordinator #131 revealed that they were aware of documentation requirements for appropriate post fall follow up.

DNC #124 confirmed the homes expectation was that the home's policies were followed. [s. 8. (1) (a),s. 8. (1) (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 Falls Prevention and Management policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone.

A review of clinical records revealed that resident #006 was admitted to the home with multiple comorbidities.

The DNC provided a summary of incidents which revealed four critical incidents were reported to the Ministry of Health and Long Term Care (MOHLTC), seven incidents reported through the home's internal risk management process and two incidents reported in the plan of care involving resident #006 over a nine month period, related to responsive behaviours.

Interview with PCA's #137 and #134 revealed that resident #006 had specific interventions in place related to responsive behaviours.

Interview with RPN #115, #142 and the DNC #124 indicated that this resident had been seen by the Behavioural Support Ontario (BSO) team and the Geriatric Mental Health Outreach Team (GMHOT) and specific interventions were implemented.

DNC #124 confirmed that despite BSO and GMHOT recommendations, and all other individualized responsive behavioural approaches for resident #006 they still failed to protect all residents from abuse. [s. 19. (1)]

2. The licensee has failed to protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Resident #006 required two people to assist with repositioning and was on a hourly repositioning program while they were in bed as well as specific monitoring checks.

Review of resident #006's progress notes revealed that the resident was found in bed at 1600 hours by staff members in a brief that was applied on the midnight shift. At that time the resident was provided care and found to have extreme excoriation to their perineum.

An internal investigation was commenced and completed soon after the incident.
It was determined that PCA #137 was responsible for resident #006's care on that day, that false documentation had occurred, the resident and brief had not been checked and repositioning hourly had not occurred.

Interview with DNC #124 confirmed that PCA #137 had documented false information and neglected resident #006's personal care.

DNC #124 indicated that her expectation was that all residents be protected from abuse and neglect. [s. 19. (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 all residents were protected from abuse by anyone, to be implemented voluntarily.

WN #6: 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin including skin break down, pressure ulcers, skin tears or wounds, receives an assessment by a member or the registered nursing staff, using a clinically appropriate instrument that is specifically designed for skin and wound assessment.

Resident #003 was observed to have an area of altered skin integrity.

Interview with PCA's #122 & #123 revealed that this area frequently breaks down and then closes. The area of altered skin integrity was noted on a bath spa sheet for a specified month.

Review of the TAR revealed this area of impaired skin integrity was not being monitored by registered staff members.

RPN #120 and #115 both confirm that this area had not received a clinically appropriate assessment.

DNC #124 confirmed the expectation was that all areas of altered skin integrity would have received an assessment by a registered staff member using a clinically appropriate instrument specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member or the registered nursing staff.

Resident #003 was observed to have an area of altered skin integrity.

Interview with PCA's #122 & #123 revealed that this area frequently breaks down and then closes.
The altered area of skin integrity was noted on a bath spa sheet for a specified month, however there was no further documentation of this area on the twice weekly bath sheets up to the time of inspection.

RPN #120 and #115 both confirm that this area had not received weekly assessments and was not documented on the TAR.

DNC #124 confirmed the expectation was that all areas of altered skin integrity would have received weekly assessments by a registered staff member. [s. 50. (2) (b) (iv)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives an assessment by a member or the registered nursing staff, using a clinically appropriate instrument that is specifically designed for skin and wound assessment and has been reassessed at least weekly by a member or the registered nursing staff, to be implemented voluntarily.

WN #7: 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 demonstrating responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the residents responses to interventions were documented.

In 2015 resident #006 had responsive behaviours resulting in critical incident reports or internal incident reports 15 times. The resident was seen by a specialist team and provided recommendations for interventions to be put into place to assist in managing this resident's behaviours. One of the interventions was for staff to monitor and document on the resident's behaviours every thirty minutes on a specific form. The resident's care plan had been updated to reflect the new changes in care.

Review of the every 30 minute monitoring form from the time the interventions were put into place to January 14, 2016, revealed missing documentation 15 times.

Interview with DNC #124, RPN #115 and BSO Lead/RPN #142 confirmed that the documentation of the every 30 minute DOS intervention was not completed or documented.
DNC #124 confirmed the expectation was that interventions set out in the plan of care be implemented and documented.

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 residents responses to interventions are documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents’ Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents’ Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents’ Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee sought the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its result.

The General Manager confirmed that the 2014 satisfaction survey was conducted and the information was compiled by the Administrative Coordinator #135. The Administrative Coordinator #135 was unaware if the home sought advice from the Family Council the development or carrying out of the satisfaction survey. [s. 85. (3)]

2. The licensee has failed to ensure that the home sought the advice of Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

An interview with the General Manager and Administrative Coordinator #135 confirmed that the home conducts two separate surveys.
The Administrative Coordinator #135 indicated that Quality of Life Surveys are completed annually with assistance of staff with resident's with a Cognitive Performance Scale of 3

or less.

The Resident/Family Satisfaction Survey is mailed out annually to the Substitute Decision Maker or given to cognitive resident's who wish to complete on their own.

The General Manager and Administrative Coordinator #135 both confirmed that the 2015 Resident/Family Satisfaction Survey were not completed.

The 2014 Resident/Family Satisfaction Survey was completed and information was compiled however, the General Manger confirmed that the results were not shared with the Residents' Council.

During an interview with the Resident Council President, the resident was unsure if the council's advice was sought in developing and carrying out the satisfaction survey.

During a review of the Resident Council Meeting Minutes the minutes did not reflect that advice was sought in the development or carrying out of the home's Resident/Family Satisfaction Survey. [s. 85. (3)]

3. The licensee has failed to ensure that the home document and make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

The General Manager confirmed that a 2014 satisfaction survey was conducted and the results compiled however they were not made available to the Family Council in order to seek the advice of the council. [s. 85. (4) (a)]

4. The licensee has failed to ensure that the results of the satisfaction survey were made available to the Residents' Council in order to seek the advice of the Council about the survey.

During an interview with the Resident Council President, the resident was unsure if the results of the Resident/Family Satisfaction Survey were made available to council.

A review of the Resident Council Meeting Minutes revealed the minutes did not reflect that the results of the Resident/Family Satisfaction Survey were made available to the council.

The General Manager confirmed that the 2014 Resident/Family Satisfaction Survey results were not made available to Resident Council, and that the 2015 Resident/Family Satisfaction Survey was not completed and therefore the results were not made available to council. [s. 85. (4) (a)]

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 licensee seek the advice of the Resident and Family Council in developing and carrying out the satisfaction survey, and in acting on its result and also to ensure that the results of the satisfaction survey were made available to the Residents' and Family's Council, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for the cleaning of the home, including, common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

On January 4, 2016, during the dining observation in the Lasalle dining room, it was noted that along the wall under the servery counter, the half dividing wall, along the baseboard heater under the window and chair legs, under table tops and table legs had significant amount of dried or splattered food debris.
Similar observations were made after the lunch service in the Belle River and Sandwich Towne dining rooms.

A review of the Resident Council meeting minutes revealed that a concern was brought

forward July 20, 2015, related to the edges of the dining room tables and arms of the dining room chairs feeling sticky. Follow up was completed and staff were reminded to ensure that tables and chairs were wiped clean.

Interviews with two Dietary Aides #101 and #102 indicated that cleaning of these areas and furnishings were not part of the cleaning list for dietary staff, both believed that this was a housekeeping task.

Interview with the Director of Environmental Services #100 revealed that this was a task completed by the housekeeping staff as part of the deep clean schedule.

A review of the Common Area Deep Clean Record - Belle River revealed that the task for cleaning Dining Room chairs & tables were scheduled to be completed November 2015, however the deep clean record had not been initialled by staff as completed.

Director of Environmental Services #100 indicated that there was not a specific policy to address these areas of concern, but that future planning was required to ensure this task was completed.

Director of Environmental Services #100 indicated that the home's expectation was to ensure all furnishings and equipment including tables, chairs, and walls are kept clean and sanitary.

Director of Environmental Services #100 confirmed that extra staff was scheduled January 8, 9, 10, 11 & 12, 2016, to complete extra cleaning to ensure the dining rooms and the furnishings were cleaned. He also confirmed that the home was developing routines to ensure extra cleaning is completed quarterly for all dining rooms and furnishings within the dining rooms. The home did determine that some of the stickiness on the dining room tables and chairs was related to the finish on these furnishings deteriorating and a plan for refinishing is in place for Spring 2016. [s. 87. (2) (a)]

2. The licensee has failed to ensure that procedures are developed and implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

During stage 1 of the RQI inspector #518 observed resident #049 in a wheelchair covered with wet and dry food debris. She also observed resident #004 in a wheelchair where the seat and foot pedals were dirty and stained with food debris. On January 15,

2016, resident #048 was observed to have a broken arm rest and their wheelchair seat was disrepair. Resident #047 was also observed January 15, 2016, to have dried food debris on the bottom of their wheelchair.

In an interview with the Exercise Therapist #140 he shared that he is responsible for arranging Shopper's Home Health to come to the home quarterly and complete cleaning clinics for all equipment. The last cleaning clinic was held in September 2015 and the next cleaning clinic will be held in January 2016. We observed the wheelchairs identified and were able to confirm by the sticker's on the wheelchairs that they had been cleaned in September 2015. Resident #047 was using a loaner wheelchair while waiting for their own fitted wheelchair to arrive. He shared that the home does not have a policy related to wheelchair cleanliness, but there are procedures in place to ensure the cleanliness of the wheelchairs are maintained. He shared that the night staff PCA's are responsible for cleaning the wheelchairs between the cleaning clinics held in the home.

Interviews conducted with PCA's #134 & #139 revealed that the night staff PCA's were responsible for the cleaning of the wheelchairs. This was to be completed twice a week and there was a checklist to sign to indicate when the chair was last cleaned by staff. PCA staff on two different Neighbourhood's were unable to locate the completed checklists for December 2015 and January 2016 to confirm the wheelchair cleaning is taking place on a regular basis.

DNC #124 was made aware of the uncleanliness of the wheelchairs and that the PCA's were unable to find the checklists to confirm that the cleaning of the wheelchairs had been completed during a discussion on January 14, 2016. She confirmed the PCA's were to be documenting wheelchair cleaning on their checklists when completed. [s. 87. (2) (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 procedures are developed and implemented for the cleaning of the home, including, common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces and also that procedures are developed and implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids, to be implemented voluntarily.

Issued on this 19th day of February, 2016

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

Original report signed by the inspector.

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALICIA MARLATT (590), ALISON FALKINGHAM (518), TERRI DALY (115)
Inspection No. / No de l'inspection :	2016_349590_0001
Log No. / Registre no:	017611-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 2, 2016
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF ASPEN LAKE 9855 McHugh Street, WINDSOR, ON, N8P-0A6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dana Houle

To Schlegel Villages Inc, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall ensure that resident #043 receives fingernail care, including the cutting of fingernails. The licensee shall develop a plan for monitoring the provision of this care to ensure compliance for this resident.

Grounds / Motifs :

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

Resident #043 was observed during stage 1 of this RQI by inspector #518. The resident had bilateral hand contractions with no pressure relieving devices in their palms. The resident's fingernails were observed to be long and digging into their palms; there were red marks in their palms indicating the nails were in fact applying pressure into their palms.

Review of resident #043's progress notes revealed that they had an infection in one their nails in 2015, turning the nail black and was described as fungus in the progress note.

Review of resident #043's care plan revealed they are dependent on staff members to complete all aspects of their care, including fingernail trimming.

Review of resident #043's hygiene and grooming records for November 2015, until January 8, 2016, indicated fingernail care was provided by the PCA's on only seven days.

The homes policy titled "Spa (Shower, Tub Bath, Sponge Bath)" last revised on January 8, 2015, policy number: 04-06 was reviewed. The policy indicated that

residents will be provided a bath, shower or bed bath at a minimum of twice a week. The policy also indicated in the procedure section 13. that "After bathing is completed, provide nail care to feet and hands."

Interview with resident #043 revealed that fingernail care was not always completed by staff and that their hands can hurt sometimes from the fingernails digging into their palms.

Interview with PCA #133 revealed that fingernail care is completed by the PCA's on bath days and is documented on the residents Personal Care Observation and Monitoring Form.

RPN #116 confirmed that resident #043's fingernail care had not been completed on spa days according to the home's policy. [s. 35. (2)]

Of the 40 residents observed this was the only resident observed to have long fingernails, making this an isolated incident. The severity of risk is minimal harm/risk for potential for harm as the resident did have a previous nail infection and continues to have contracted hands. The home's compliance history reveals the home was previously issued a Voluntary Plan of Correction for lack of fingernail care on October 6, 2015. (590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 11, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 2nd day of February, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Alicia Marlatt

Service Area Office / Bureau régional de services : London Service Area Office