**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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 28, 2016 | 2016_532590_0030 | 026629-16 | Critical Incident System |

**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)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): November 3 and 4, 2016.**

**This inspection was related to the prevention of abuse and neglect.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care, two Registered Practical Nurses (RPN) and one Personal Support Worker (PSW).**

**During the course of the inspection, the inspector(s) reviewed two resident clinical records, one Critical Incident Report and the home's policy related to abuse and neglect.**

**During the course of the inspection, the inspector(s), observed resident to resident interactions and staff to resident interactions.**

**The following Inspection Protocols were used during this inspection:**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

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

**1 WN(s)**
**1 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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 failed to ensure that the provision of the care set out in the plan of care was documented.

An incident had occurred involving resident #001. After the incident, an intervention was initiated to ensure the safety of resident #001, including specific documentation for direct care staff.

A review of resident #001's care plan revealed that the intervention was initiated for a seven day time period, beginning from the evening of the incident.

A review of documentation for the seven day time period after the incident revealed that only 73% of the specific documentation was completed.

In an interview with DOC #100, she confirmed that resident #001 was to have specific documentation completed by the staff for a seven day time period after the incident. She confirmed that the documentation was incomplete. DOC #100 shared that the home's expectation was that direct care staff were to provide the intervention and complete the specific documentation for resident #001. [s. 6. (9)]

***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 provision of the care set out in the plan of care is documented, to be implemented voluntarily.***

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**Issued on this 28th day of December, 2016**

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

**Original report signed by the inspector.**