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 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
Dec 20, 2018	2018_533115_0026	019248-18, 022620-18, 028092-18, 029251-18, 031518-18, 032068-18	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

TERRI DALY (115), CASSANDRA TAYLOR (725), KARIN MUSSART (145)

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 26, 27, 28, 29, 30, December 3 and 4, 2018

The following Critical Incident inspections were conducted:
Related to falls prevention:
Critical Incident Log #028092-18 / 3037-000050-18
Critical Incident Log #029251-18 / 3037-000052-18
Critical Incident Log #019248-18 / 3037-000037-18
Critical Incident Log #032068-18 / 3037-000062-18

Related to controlled substance missing/unaccounted:
Critical Incident Log #022620-18 / 3037-000039-18

Related to failure/breakdown of major system:
Critical Incident Log #031518-18 / 3037-000060-18

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), the Director of Nursing Care (DNC), the Assistant Director of Nursing Care (ADNC), the Resident Assessment Instrument (RAI) Coordinator, the Exercise Therapist, the Environmental Services Manager, two Registered Practical Nurses (RPN), three Personal Support Workers (PSW), one Neighbourhood Coordinator, one Housekeeping Aide (HA).

The inspectors also observed residents and the care provided to them, monitored temperatures, reviewed environmental records related to temperatures, health care records and plans of care for identified residents, relevant policies and procedures of the home, critical incidents and the home's investigative notes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Hospitalization and Change in Condition
Medication
Safe and Secure Home

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

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

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A Critical Incident Systems (CIS) report was submitted to the Ministry of Health and Long-term Care (MOHLTC) on a specific date.

During a record review it was determined that the resident had a history of specific incidents.

During staff interviews with; Personal Support Worker (PSW) #103, Registered Practical Nurse (RPN) #104, RPN #101, Exercise Therapist #100 and the Director of Nursing Care (DNC) #102, they indicated that information and direction related to the incidents and that were specific to the resident would be located in the resident care plan in Point Click Care (PCC) or Point of Care (POC) and that all staff had access to the care plan.

During a staff interview with DNC #104 they said a specific care plan was not initiated until a certain date, but stated conversations had transpired about resident # 001's incident history.

During a staff interview with Exercise Therapist #100 they acknowledged that a specific care plan was not initiated until a certain date, and that conversations related to specific interventions with both staff and family had not been documented.

The licensee has failed to ensure that the care set out in the plan of care for resident #001 was based on an assessment of the resident and their needs. [s. 6. (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 to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date.

During a record review clinical records for resident #004 indicated that an incident occurred on a specific date, resulting in an injury to the resident. An incident report was completed by Registered Practical Nurse (RPN) #111, but no post fall incident/assessment was completed.

During an interview with RPN #104 it was stated that part of the post falls program included a post falls incident/assessment report that was to be completed in Point Click Care (PCC).

During a record review of the homes policy tilted; Falls Prevention & Management Program [LTC] it stated under the Registered Nursing Team Member section 6. "Document post fall assessment using the Falls Incident Report located in the computerized software system."

During an interview with Assistant Director of Nursing Care (ADNC) #106 it was confirmed that a falls incident report that included a post falls assessment should be completed after every resident fall.

The licensee has failed to ensure that resident #004 had a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (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 to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

Issued on this 27th day of December, 2018

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

Original report signed by the inspector.