Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
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Original Public Report

Report Issue Date: August 21, 2023
Inspection Number: 2023-1465-0005
Inspection Type: Complaint Critical Incident System
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Aspen Lake, Windsor

Lead Inspector	**Inspector Digital Signature**
Adriana Congi (000751)	Adriana Congi Digitally signed by Adriana Congi Date: 2023.08.24 11:56:21 -04'00'

Additional Inspector(s)
Jennifer Bertolin (740915)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 9-11, 2023 and August 14-17, 2023.

The following intakes were inspected:

- Intake #00086917 was related to falls prevention and management;
- Intake #00087453 was related to responsive behaviour; and
- Intake #00091357 was related to continence care, housekeeping services, and resident care and support services.

The following intake was completed in this inspection:

- Intake #00091636 was related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Continence Care
Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Missing weekly skin and wound assessment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that any resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A review of a resident's clinical record showed that the resident had an alteration in skin integrity. The home initiated weekly skin and wound assessments. There was one missing weekly skin and wound assessment.

The home's skin and wound care program directed registered nursing staff to reassess altered skin integrity at least weekly and as needed.

During an interview with the Skin and Wound Lead, they confirmed that the skin and wound assessments should have been completed weekly per the home's policy.

Sources: Resident's clinical record; Skin and Wound Care Program; and interview with Skin and Wound Lead.

[000751]

WRITTEN NOTIFICATION: Behaviours & Altercations

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (b)

The licensee failed to ensure that staff were made aware at the beginning of the shift that a resident had required heightened monitoring during previous shifts due to responsive behaviours.

A review of the resident's clinical record for previous shifts indicated that registered staff requested heightened monitoring due to responsive behaviours.

During an interview with a registered staff, they stated they were not made aware that there was heightened monitoring for a resident due to responsive behaviours on previous shifts.

The Assistant Director of Nursing stated the expectation is for direct care staff to make the oncoming staff aware at the beginning of each shift when a resident is on heightened monitoring.

Sources: Resident's clinical record; Interview with direct care staff and management

[740915]