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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: February 5, 2024	
Inspection Number: 2024-1465-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Aspen Lake, Windsor	
Lead Inspector Julie D'Alessandro (739)	**Inspector Digital Signature** Julie D'Alessandro Digitally signed by Julie D'Alessandro Date: 2024.02.07 13:32:37 -05'00'
Additional Inspector(s) Jennifer Bertolin (740915) Adriana Tarte (000751)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 17, 19, 22, 25, 26, and 29, 2024
The inspection occurred offsite on the following date(s): January 18, 23, and 24, 2024

The following intakes were inspected in this inspection:
Intake: #00097575-complaint related to personal care and support services, medication management, and continence care
Intake: #00106635-complaint related to medication management
Intake: #00100596/Critical Incident (CI) #3037-000050-23 related to medication management
Intake: #00101280/CI #3037-000052-23 related to alleged neglect
Intake: #00102193/CI #3037-000057-23 related to resident care and services

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Intake: #00103666/CI #3037-000059-23 related to continence care
Intake: #00105434/CI #3037-000001-24 related to an unexpected death
Intake: #00106298/CI #3037-000003-24 related to falls prevention and management

The following intake was completed in this inspection: Intake # 00094286/CI #3037-000035-23 related to falls prevention and management.

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident

Introduction:
The licensee failed to ensure that the plan of care for a resident set out clear directions for the staff providing care to the resident.

Rationale and Summary:
It was documented that while a resident was receiving care there was trauma and bleeding occurred.

The resident's clinical record did not include clear direction to the staff delivering the care.

During an interview with an Associate Director of Care (ADOC), they acknowledged that the plan of care for the resident did not include clear directions for staff providing care.

Sources: resident clinical record, as well as staff interviews
[739]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, 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.

A) Introduction
The licensee failed to ensure that a resident received a skin assessment by a member of the registered nursing staff when exhibiting altered skin integrity.

Rationale and Summary
Staff had been notified of an area of altered skin integrity on a resident.

Registered staff confirmed that an initial skin and wound assessment should have been completed immediately but was not.

Failure to complete a skin assessment when the resident exhibited altered skin integrity placed the resident at risk of wound deterioration.

Sources: Resident's clinical record and staff interviews
[000751]

B) Introduction
The licensee failed to ensure that a second resident received a skin assessment by a member of the registered nursing staff when exhibiting altered skin integrity.

Rationale and Summary
An electronic mail (e-mail) was sent to the resident's physician indicating that the resident had an area of altered skin integrity and treatment was ordered however, an initial assessment of the area was not completed by registered staff.

An ADOC and Director of Care (DOC) both acknowledged that an initial skin assessment should have been completed by registered staff but was not.

Failure to complete a skin assessment when the resident exhibited altered skin integrity placed the resident at risk of skin deterioration.

Sources: Resident's clinical records, staff interviews, and e-mail correspondence [740915]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds.

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

Introduction
The licensee failed to ensure that a resident, who was exhibiting altered skin integrity, received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection.

Rationale and Summary
Two separate e-mails, for an area of impaired skin integrity, indicated that the resident was to have a treatment for altered skin integrity and an ADOC had followed-up with registered staff.

The physician's medication order sheet was reviewed and neither treatment had been ordered for the resident.

An ADOC acknowledged that the resident did not receive immediate treatment as recommended.

Medication orders were not completed which put the resident at risk for not receiving treatment interventions to promote healing and prevent infections.

Sources: Resident's clinical records, staff interviews, and e-mail correspondence [740915]

WRITTEN NOTIFICATION: Resident Records

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

Introduction
The licensee failed to ensure that a resident's written record was kept up to date.

Rationale and Summary
Review of a resident's clinical record was missing documentation, that the care had been provided, on several dates.

An ADOC acknowledged that documentation was not completed for the resident and their written record was not kept up to date.

Lack of documentation on the resident compromised the quality and safety of care.

Sources: Resident's clinical record and staff interviews
[740915]