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 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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## 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 |
|---|---|---|---|
| Nov 10, 2015 | 2015_216144_0057 | 010463-15 | 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 at St.Clair
1800 Talbot Road WINDSOR ON 000 000

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CAROLEE MILLINER (144), ALICIA MARLATT (590), ALISON FALKINGHAM (518)

### 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): October 20, 21, 22, 23, 26, 27, 2015.**

**Complaint 002793-15 related to housekeeping and nursing and personal care services was completed during the Resident Quality Inspection (RQI).**

**The following Critical Incidents were inspected with the RQI:**
**019808-15 related to abuse,**
**018070-15 related to responsive behaviours,**
**020367-15 related to the plan of care and,**
**013539-15, 020261-15, 024247-15, 020194-15 related to falls.**

**During the course of the inspection, the inspector(s) spoke with 40+ residents, three family members, the General Manager, Director of Nursing Care (DNC), Assistant Director of Nursing Care (ADNC), Director of Food Services (DFS), Assistant Director of Food Services (ADFS), the Registered Dietitian (RD), one Registered Nurse (RN), ten Registered Practical Nurses (RPN's), nine Personal Support Workers (PSW's), one Restorative Care Aide (RCA) and three Housekeeping Aides.**

**During the course of the inspection, the Inspector(s) toured all Resident Home Areas (RHA), medication rooms, observed dining service, medication administration, provision of care, recreational activities, resident/staff interactions, infection prevention and control practices, reviewed residents clinical records, posting of required information, meeting minutes related to the inspection and relevant policies and procedures.**

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

**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Skin and Wound Care**

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

- **3 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 O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that residents were monitored during meals, including residents eating in locations other than dining areas.

A) The home's Meal Service-Tray policy, last revised April 22, 2015, stated that residents receiving food trays will be monitored during the meal service by a nursing team member as per the home's policy.
B) One resident was observed during the RQI to have an empty meal tray sitting on their bed side table.
C) The resident's clinical record confirmed their diagnosis and that they required supervision by nursing staff during the meal process.
D) The resident's family member shared with one Inspector that he was aware the resident received tray service and believed the resident has not been given the assistance and supervision required to eat their meals.
E) On a different date, the Inspector observed that the same resident had a lunch tray brought to their room by a PSW. The Inspector went into the residents room and observed them eating their meal without being monitored.
F) One RN observed and confirmed that the resident was eating their meal unsupervised in their room.
G) The Food Service Supervisor advised the Inspector the resident's Substitute Decision Maker (SDM) had signed a waiver allowing meals to be taken in thier room. The waiver was reviewed by the Inspector.
H) The RD, DFS and ADFS confirmed the expectation was that all residents will be monitored during their meals. [s. 73. (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 residents are being monitored during meals, including residents eating in locations other than dining areas, to be implemented voluntarily.***

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**WN #2: 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 failed to ensure that the home's wound and skin care policy complied with.

A) One resident had altered skin integrity which required monitoring.
B) Review of the resident's clinical record revealed weekly assessment documentation was completed on the home's tool specifically used for weekly assessments of altered skin integrity on two identified dates.
C) Inspector #590 was unable to locate assessments for the altered skin integrity on the home's tool specifically used for weekly assessments prior to and after specific identified dates.
D) Review of the progress notes for the resident revealed multiple entries that indicated the resident's wound was monitored by the registered staff, the Nurse Practitioner (NP) and Physician on specific dates.
E) The Assessment section of the home's Wound/Skin Care policy, last revised August 21, 2015, provided direction for the assessments.
F) Interview with the DNC revealed that assessment documentation completed by the NP and Physician would continue to be documented in the progress note section of the resident's clinical record as they were not required to use the Wound Assessment Tool.
G) The DNC confirmed that it was the expectation of the home that weekly wound assessments completed by registered staff will be documented on the Wound Assessment Tool specifically specifically used for weekly skin and wound assessments.
[s. 8. (1) (a),s. 8. (1) (b)]

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

A)The Home's Policy Food Services Receiving and Storing Tab 05-06 last revised November 2012 states that refrigerator temperatures will be monitored twice a day using a calibrated thermometer.
B) On October 19, 2015, one Inspector observed the dining service in one Resident Home Area.
C) While inspecting the servery it was noted that the fridge and freezer Refrigeration Temperature log was incomplete.
D) This was confirmed by the Registered staff member on the unit .
E) The missing temperature documentation occurred on:
October 3, 2015 PM shift
October 9, 2015 AM shirt
October 10, 2015 AM shift
October 12, 2015 AM and PM shifts
October 18, 2015 AM shift
F) The Dietician, Food Services Manager and Assistant Food Services Manager confirmed the temperatures were not taken and the Food Services Policy was not complied with. [s. 8. (1) (b)]

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement**

**Specifically failed to comply with the following:**

**s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:**
**1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**3. The use of the PASD has been approved by,**
**i. a physician,**
**ii. a registered nurse,**
**iii. a registered practical nurse,**
**iv. a member of the College of Occupational Therapists of Ontario,**
**v. a member of the College of Physiotherapists of Ontario, or**
**vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).**
**4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).**
**5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure the use of a Personal Assistive Safety Device (PASD) under subsection (3), to assist a resident with a routine of daily living may be included in the resident`s plan of care only if: The use of the PASD has been consented to by the resident or, if the resident is incapable, a Substitute Decision-Maker (SDM)of the resident with the authority to give consent.

A) One resident was observed using a PASD each day of the Resident Quality Inspection (RQI).
B) Review of the resident's clinical record confirmed a physician's order for the PASD.
C) Two Alternatives to Restraint PASD Assessments had been completed.
D) An Alternatives to Restraint PASD Assessment had not been completed when the physician`s order for the PASD was recorded.
E) Consent for use of the PASD, located in the resident's clinical record, was not completed (signed and dated) by the resident or, if the resident was incapable, a SDM with the authority to give consent.
F) Interview with two RPN's confirmed that the resident used PASD and that consent should have been obtained from the resident or the resident's SDM prior to it's use.
G) The DNC confirmed it was her expectation that signed consent from the resident or the resident's SDM was required for the use of a PASD. [s. 33. (4) 4.]

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**Issued on this 10th day of November, 2015**

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

**Original report signed by the inspector.**