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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 16, 2016	2016_349590_0007	003331-16 & 005506-16	Complaint

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

ALICIA MARLATT (590)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 24, 25, 26, 29, March 1, 2, 3, 4, 7, 8, 9, 10, 11 and 14, 2016.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Nursing Care (DNC), three Registered Practical Nurses (RPN), one Personal Support Worker (PSW) and one family member.

During the course of the inspection, the inspector(s) reviewed one resident's clinical record including hospital documentation, relevant policies related to inspection and notes from one previous inspection.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Infection Prevention and Control
Nutrition and Hydration
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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	Legendé 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 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 any plan, policy, protocol, procedure, strategy or system is complied with.

Resident #002 required transfer to hospital for an acute medical illness.

The home's policy titled "Transfer of Resident To Hospital Procedure", policy #: 07-04, dated January, 2013, and last revised on August 21, 2015, was reviewed by inspector.

The "Procedure" section indicated the following should occur during a transfer to the hospital:

3. Delegate a Team Member from the Resident's Neighbourhood to the front doors/parking lot to receive the ambulance and direct the attendants to the Resident.
4. A Team Member will remain with the Resident to provide comfort measures and prepare the Resident for transfer to hospital.
7. Document the transfer to hospital using the Electronic Routine Transfer Form (in the current computerized software system).

Review of the "Patient Care Report" revealed the following was documented by the Emergency Medical Service (EMS) providers who arrived on the scene:

When EMS arrived at the home they were unable to locate staff or find the resident's living area. The Community Care Access Centre (CCAC) was contacted to assist in finding staff by phone. After 15 minutes a staff person was located and took the EMS staff to the resident. The staff person gave an oral report, left and did not return until departure. The EMS noted the resident required a continence product change before leaving however no staff were located and the resident left without being assisted.

In interviews with RPN's #101, 102 and 103, they were all able to correctly explain the home's procedure for transferring a resident to the hospital during the night shifts.

During an interview with DNC #100 the EMS notes were reviewed. The DNC could not answer to the notes as she was not working in a supervisory role and had not provided care to this resident. She was able to explain the procedure for transferring a resident to the hospital. There is a charge nurse that floats on nights and is to help which ever unit needs help, for example when a resident is not doing well and requires transfer to the

hospital. On nights the building is locked and the charge nurse is responsible for buzzing the EMS into the building. One staff member is to stay with the resident and the other staff member would get the transfer papers and Medication Administration Record ready to go. One staff member is to go downstairs and wait for or meet the EMS at the door to direct them where to go. During days the staff will call down to reception and she will tell them where to go.

According to the EMS notes of the incident the home's policy was not complied with. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 15. Skin condition, including altered skin integrity and foot conditions.

Resident #002 had multiple comorbidities requiring frequent hospitalizations during their time at the home. They required ongoing use of a medical device which required care and monitoring from the staff in the home.

The resident was admitted to the hospital three times during a two month period. During these admissions the staff at the hospital observed this residents skin to have alterations in it's integrity related to the ongoing use of the medical device.

Review of the hospital record documentation revealed that three physician's and one Enterostomal Therapist (ET) had seen this resident and made annotations related to the use of the medical device and it's association with the skin integrity issues.

Review of resident #002’s skin assessments after their return from each hospital admission revealed no indications of a skin impairment.

Review of resident #002’s progress notes for their whole stay in the home was reviewed. The notes mention frequent difficulties with caring for the medical device, however there was no documentation pertaining to skin impairments.

DNC #100 could not answer questions or confirm any information as she was not working in a supervisory position at that time and had not provided care to this resident. The ED also could not answer any questions or confirm any information as she was not employed by the home at that time. The DNC did confirm that any alterations in skin integrity should be documented by the PSW’s and registered staff on the required documents. She confirmed that skin alterations should be assessed and monitored by registered staff so that care can be planned according to the resident needs. [s. 26. (3) 15.]

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 plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 15. Skin condition, including altered skin integrity and foot conditions., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident's written record is kept up to date at all times.

The EMS report identified that when paramedics arrived at the home in response to a call concerning resident #002, they were unable to locate the resident for fourteen minutes as they were unable to locate staff.

Review of the resident's clinical record revealed there was no documentation in the progress notes related to EMS services being contacted by the home and the resident's subsequent admission to hospital on the same date.

The home's Transfer and Referral report identified the date of the resident's transfer to hospital. The DNC #100 advised the home switched their computer software program in the summer and the resident's information may not have transferred properly to the new program.

DNC #100 confirmed the clinical record for the resident should have included information related to the need to contact EMS and the resident's admission to hospital.

The ED #105 confirmed that the resident's clinical record during the above occurrence, had not been kept up to date. [s. 231. (b)]

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 resident's written record is kept up to date at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respected and promoted the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

Review of resident #002's Multiple Data Set (MDS) assessment, indicated this resident is incontinent of their bowels and required assistance from staff due to physical limitations to complete the toileting task. This resident was cognitively aware and alert.

Review of the "Patient Care Report" obtained from the hospital revealed that the resident required a continence product change prior to departure from the home and the EMS was not able to locate staff to assist this resident in being changed.

In an interview with DNC #100 she indicated that she was not the DNC at that time and could not explain why this situation happened and confirmed that their Neighbour's are to be provided care they each need, while having their dignity respected. She was able to explain the home's procedure for transferring a resident to the hospital and confirmed that the resident should have been changed prior to the transfer to hospital. [s. 3. (1) 1.]

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Issued on this 3rd day of June, 2016

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

Original report signed by the inspector.