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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 18, 2018	2018_747725_0017	015336-18, 024601-18, 024781-18, 025106-18	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 N9H 0E3

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

CASSANDRA TAYLOR (725)

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): October 1 - 5 and 9 - 12, 2018.

Complaint inspection: log# 024601-18/IL-59592-LO/ IL-59660-LO was related to responsive behaviours and prevention of abuse and neglect;
Complaint inspection: log# 015336-18/IL-57580-LO was related to skin and wound management, plan of care, continence care and bowel management and administration of drugs;
Critical Incident System (CIS) inspection: Log #025106-18/CIS #3046-000061-18 relating to responsive behaviours and prevention of abuse and neglect;
Critical Incident System (CIS) inspection: Log #024781-18/CIS# 3046-000058-18 relating to responsive behaviours and prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Nurse Manager, two registered nurses (RN), three Registered Practical Nurses (RPN), two Personal Support Workers (PSW), one Recreation Aide, two agency staff.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, infoline reports, Critical Incident System reports, internal incident reports and policies and procedures relevant to inspection topics.

During the course of the inspection, the inspector(s) observed infection prevention and control practices, the provision of resident care including resident specific routines and staff and resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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	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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee had failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A resident was identified as having had a change in continence level with increased bowel incontinence.

Review of the clinical record showed that the resident began having increased episodes of both urinary and bowel incontinence. During that time the resident was treated successfully for an infection. After this infection it was noted again that the resident was having increased episodes of incontinence with ongoing documentation.

Review of the clinical record showed that a continence evaluation assessment was completed for the resident which indicated a sudden worsening in bowel incontinence with a few movements per week. Interventions were noted to promote and manage bladder incontinence with no plan to promote or manage bowel incontinence based on the assessment. Another continence evaluation assessment was completed at a later date. This assessment indicated worsening in bowel incontinence with movements occurring multiple times per day, again with no plan to promote or manage bowel incontinence based on the assessment.

During an interview the Assistant Director of Care (ADOC) confirmed that the resident was incontinent of bowel and that there were no interventions documented to promote and manage bowel continence based on the assessment.

The licensee had failed to ensure that the resident had an individualized plan, as part of his or her plan of care, to promote and manage bowel continence based on the assessment and that the plan was implemented. [s. 51. (2) (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 each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee had failed to ensure that all medical directives or orders for the administration of a drug to a resident were reviewed at any time when the resident's condition was assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act.

A resident was identified as having issues with their medications. Which required them to be given a specific drug.

Review of the clinical record indicated that during a medication review the Nurse Practitioner (NP) noted an order duplication error. The NP wrote an order to discontinue a specific medication with a specific frequency and start that same medication with a different frequency. Both of these orders stayed on the Electronic Medication Administration Record (EMAR) until the NP discovered the error.

Review of the EMAR indicated that staff signed daily that both orders were given a specific number of time while it was on the EMAR. The EMAR indicated that a specific number of the days there was a progress note from the registered staff giving medications that there was a duplication in the order and medication was not given or not available.

During an interview with Director of Care (DOC) #100 it was indicated that some of the registered staff that had signed no longer worked at the home but the registered staff that did work at the home were interviewed and confirmed the medication was not available to give. DOC #100 confirmed this was an error where the order continued on the EMAR when it should have been discontinued.

Review of the pharmacy shipping reports from MediSystem Pharmacy Limited indicated that a specific number of tablets of a specific medication were sent weekly. The amount shipped would fulfill only the last written order.

The licensee had failed to ensure that all orders for the administration of a drug to the resident were reviewed at any time when the resident's condition was assessed or reassessed in developing or revising the resident's plan of care. [s. 117. (a)]

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 all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act, to be implemented voluntarily.

Issued on this 18th day of October, 2018

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

Original report signed by the inspector.