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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 19, 2018	2018_532590_0020	001655-18, 011067-18, 023065-18	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

ALICIA MARLATT (590), 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.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Assistant Director of Care, a Neighbourhood Coordinator, the Director of Environmental Services, one Housekeeper, two Registered Nurses, four Registered Practical Nurses, six Personal Support Workers and two family members.

During the course of the inspection, the inspector(s) observed resident rooms, the meal and snack services, infection prevention and control practices, the posting of required information, resident and staff interactions and toured all resident home areas.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, Infoline reports, Critical Incident System reports, Resident/Family Concern forms and policies and procedures relevant to inspection topics.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dining Observation
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that actions were taken to meet the needs of the resident with responsive behaviours including: assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) from resident #005’s family member on August 23, 2018, identifying concerns about resident #004's behaviours affecting resident #005 and other residents.

Review of resident #004’s physician’s orders showed an order written on a specified day in 2018, to consult the Geriatric Mental Health Outreach Team (GMHOT) for specific behaviours. Further review of the clinical record after the order was written, showed no notes completed by the GMHOT, or the home's internal Personal Expressions Response Team (PERT).

In an interview with Registered Practical Nurse (RPN) #116 on October 11, 2018, who was also a PERT member, they shared that any resident that was awaiting a consult or assessment from the external GMHOT or Behavioural Supports Ontario (BSO) team, should be followed by the homes internal PERT. They said that they sent out an email on September 24, 2018, to all staff directing them that if a referral for the external GMHOT or BSO team was ordered, to please send an email regarding the order direction to the PERT, and to also initiate a PERT referral assessment including a summary of the expressions noted that lead to the referral. The RPN confirmed that resident #004 had not had a PERT referral and was not being followed by PERT at this time and should be followed.

In an interview with Assistant Director of Care (ADOC) #115 on October 11, 2018, they shared that the GMHOT had been notified the day the consult was ordered, however they have not yet been in to see this resident and they were on the GMHOT waiting list for assessment. The inspector asked whether the home's PERT was following this resident in the interim while waiting for the GMHOT assessment and they shared that the resident was not currently followed by the PERT. The inspector and ADOC reviewed the progress notes and this resident’s behaviours and the ADOC agreed that the PERT should have completed an assessment of this resident and provided recommendations while waiting for the GMHOT consult.

The licensee had failed to ensure resident #004 was appropriately assessed by the home's internal PERT while waiting for an external GMHOT assessment. [s. 53. (4) (c)]

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 actions taken to meet the needs of the resident with responsive behaviours include an assessment, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee had failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A complaint was received by the MOHLTC from resident #005's family member on August 23, 2018, identifying concerns about resident #004's behaviours affecting resident #005 and other residents.

Review of resident #004's clinical record, showed that the resident had mental health

issues and was cognitively impaired. The resident's care plan documented that monitoring of behaviours would be assessed using an identified tool, and would be completed as needed for medication changes, and that any episodes of displayed behaviours would be documented.

Resident #004’s current electronic Medication Administration Record (eMAR) was reviewed and showed that the resident took mind altering medications on a regular basis. Review of the physicians’ orders showed that the dosage of a specific medication had been increased on a specific day, and that the monitoring tool for seven days was ordered. That same medication dosage had also been increased the month prior, and the monitoring tool had been ordered for seven days. That medication was initiated three months prior, and the monitoring tool was ordered the previous day for a seven day time period. Also on a specific day, another medications dosage was increased and the monitoring tool was ordered for seven days.

Review of the monitoring tools for the dates that medication changes occurred were reviewed and showed that there were 336 entries to be completed in total on the form, for monitoring every half an hour for a seven day time period. The forms showed the following:
- One form specifically dated was missing 18 percent of documentation required, or 59 of 336 entries.
- One form specifically dated was missing 28 percent of documentation required, or 95 of 336 entries.
- One form specifically dated was missing 14 percent of documentation required or 46 of 336 entries.
- There were no monitoring tool forms for one identified week.

In interviews with Registered Nurse (RN) #112 and 117, they shared that the monitoring tool was to be completed for seven days when mind altering medication orders were initiated or changed so staff can monitor the effects of the medications on the residents' behaviours.

In an interview with ADOC #115, the inspector showed them the monitoring tool documentation sheets. The ADOC said that the documentation on the monitoring tools had not been completed as required and should have complete documentation.

The licensee had failed to ensure that resident #004 was monitored for behaviours after their medication dosages changed using the identified monitoring tool as outlined by the

home's processes. [s. 134. (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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

A written complaint was submitted to the MOHLTC on May 23, 2017, from resident #001's spouse who identified concerns with pain and continence care. Upon review of the home's internal complaint form there was a progress note with the same date describing an incident of abuse that was attached to the form.

On an identified day in 2017, a progress note was written by RPN #102 and it described an incident of abuse involving resident #001 by another identified person. The note documented that two PSW staff members witnessed the other identified person making demeaning and humiliating comments while assisting the staff providing care in the shower room. The note documented that the resident displayed physical resistance to the identified person when being taken out for an appointment and that the identified

person was seen semi-dragging the resident through the hallway.

Review of another concern form showed a progress note written by the DOC on an identified day earlier then the RPN's written note in 2017, which described an incident on a specific day in 2017, where a PSW witnessed the identified person hitting the resident several times over on their hand. A Critical Incident report to the MOH was submitted for that specific incident.

Inspector interviewed RPN #102 on October 2, 2018, who had written the progress note on the identified day in 2017, and provided an opportunity to the RPN to review the note. The RPN said that they recalled the incident more than a year ago and the staff members who were working and provided the inspector with their names. The inspector asked the RPN if they thought this constituted abuse and they said it did. The inspector asked the RPN if they had reported this incident to their superiors and they could not recall if they had or not. The inspector asked if this was an incident that should be reported to their superiors if witnessed today and they said absolutely this should be reported to superiors as soon as possible.

Inspector interviewed PSW #103 who was also working the identified day in 2017. The inspector provided an opportunity for the PSW to review the progress note and the PSW was able to recall the incident and confirmed that they were present. Inspector asked the PSW if they thought this incident constituted abuse and they said it did. Inspector asked the PSW if they reported this incident to their superiors and they shared they had reported it to the nurse on duty right after the incident occurred.

Review of the homes policy titled “Prevention of Abuse and Neglect”, policy number 04-06 and last reviewed on 12/06/2017 documented the following process for reporting abuse:
“All team members are required to report any suspicions, incidents, or allegations of neglect and/or abuse immediately to any supervisor or any member of the leadership team for further investigation, and to follow Section 24-Mandatory Reports.”

Upon review of the note, the inspector interviewed the DOC on October 1, 2018, who was also concerned about the information in the progress note. The current DOC was not in the DOC position at the time and was unaware of the incident. The DOC identified that the DOC at the time of the incident did not sign the complaint form indicating to them that the abuse had not been addressed. The DOC said that concerns or complaints were usually managed by the Neighbourhood Coordinators, unless they couldn’t resolve the

issue themselves and would report to the DOC for follow up. The DOC further said that the General Manager had signed the form, but the form also documented that the resident/family was satisfied with the resolution of their concerns, and also could not verify if this progress note was attached to the concern form at the time of review by the GM. The DOC said that this incident should have been reported to the management staff in the home for follow up and it appeared that it had not been reported to the appropriate persons.

The licensee had failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

Issued on this 19th day of October, 2018

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

Original report signed by the inspector.