Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 22, 2019	2019_819524_0006	016806-19, 017028-19, 018060-19, 018159-19, 019148-19	Critical Incident System

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

INA REYNOLDS (524), KRISTEN MURRAY (731)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 8, 9 and 10, 2019.

The following Critical Incident intakes were inspected during this inspection:
Log #016806-19 / CI 3046-000056-19 related to skin and wound care
Log #017028-19 / CI 3046-000023-19 related to falls prevention and management
Log #018060-19 / CI 3046-000060-19 related to falls prevention and management
Log #018159-18 / CI 3046-000061-19 related to falls prevention and management.
Log #019148-19 / CI 3046-000063-19 related to hospitalization and change in condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Assistant Directors of Care, one Neighbourhood Coordinator, the Resident Assessment Instrument (RAI) Coordinator, three Registered Practical Nurses, six Personal Support Workers and residents.

The inspector(s) also observed resident care provisions, resident and staff interactions, reviewed clinical records including plans of care for identified residents and relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) This inspection was initiated as a result of a Critical Incident System (CIS) report submitted to the Ministry of Long Term Care (MOLTC) on a specific date, regarding a fall of a resident resulting in an injury. The resident required an external medical assessment.

In a clinical record review of the resident's care plan under a focus statement, it documented that an intervention was included for an assistive device to be within reach.

In a clinical record review of the resident's fall incident assessment for a specific date, it indicated that the resident was trying to reach for their assistive device and fell when trying to do so.

In an interview with the resident, when asked if they remembered the fall they had on a specific date, the resident stated they did. When asked if their assistive device was within reach when they sustained the fall, the resident stated that they were reaching for their assistive device when they fell. The resident further stated that they needed some assistance from staff and they were trying to reach the assistive device but it was too far away and then they fell.

In an interview with Director of Care (DOC) #102, when asked what was in the resident's care plan at the time of the fall related to the specific assistive device, DOC #102 stated that the resident was to have the assistive device within reach so that they can reach it easily. When asked if the assistive device was in place at the time of the fall, DOC #102 stated that it was documented that the resident had to reach for it and if the resident needed to reach for it, the assistive device was not in place.

B) This inspection was initiated as a result of Critical Incident System (CIS) report submitted to the Ministry of Long-Term Care (MOLTC) on a specific date regarding an incident involving a resident. Review of the CIS stated that an identified resident presented with altered skin integrity for a specific period of time. Treatment orders were scheduled to be done on specific dates.

The clinical records for the resident were reviewed. Review of the Treatment Administration Record (TAR) noted a treatment was missed on a scheduled date and indicated to reference a nurses note. Record review of the nurse's progress notes by a registered practical nurse with a specific date stated that the resident had refused treatment and they would continue to redirect and approach the resident. However, there

was no indication in the progress notes that the resident had been re-approached after treatment was refused.

Record review of the resident's plan of care included specific direction to staff if the resident refused care. This was verified by Registered Practical Nurse (RPN) #107. RPN #107 said that if treatment was refused by the resident, they would re-approach a couple of times on their shift and document each approach and would also notify the registered nurse.

In an interview, on a specific date, Assistant Director of Care #106 said that the expectation was that the resident should have been re-approached at least three times after treatment was refused and to document each approach. In an interview, Administrator #100 acknowledged that the care plan should have been followed.

The licensee failed to ensure that the care set out in the plan of care for the identified residents was provided to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 23rd day of October, 2019

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

Original report signed by the inspector.