Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Feb 7, 2020	2020_777731_0002	022445-19	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

KRISTEN MURRAY (731)

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): January 2, 3, 6, 7, 8, 9, 10, 13, 16, 17, 20, and 21, 2020.

The following Complaint intake was completed within this inspection:

Complaint IL-72321-LO / Log # 022445-19 related to falls prevention and management, medication, Power of Attorney (POA) notification, personal hygiene care, pain management, hospitalization and change in condition, nutrition and dining services, and continence care.

During the course of the inspection, the inspector(s) spoke with the General Manager, the acting Director of Care (DOC), Assistant Directors of Care (ADOCs), a Nurse Practitioner (NP), a Neighbourhood Coordinator, the Registered Dietitian (RD), the Physiotherapist (PT), a Registered Nurse (RN), an Exercise Therapist, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Recreation Aide, and a Dietary Aide.

The inspector also reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 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	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were consistent with and complemented each other.

Complaint IL-72321-LO was submitted to the Ministry of Long Term Care (MOLTC) regarding a number of care concerns including concerns regarding falls prevention and management of resident #001.

A review of the home's policy "Falls Prevention & Management", number 04-29, last revised August 2019, stated "It is the policy of Schlegel Villages to ensure residents are assessed for their potential risk for falls, minimise these risks wherever possible, and ensure post-fall management, including treatment, documentation, and communication of any witnessed or un-witnessed falls for the safety of all residents".

In a clinical record review of resident #001's progress notes and falls assessments in Point Click Care (PCC), it identified that resident #001 sustained falls on a number of specified dates.

In a clinical record review of resident #001's Resident Assessment Instrument – Minimum Data Set (RAI-MDS), with a specified assessment reference date, under section "J4 Accidents", it indicated the resident had not sustained a fall in the past 30

Resident Assessment Protocol (RAP), under the “Falls” section, on a specified date, it stated resident #001 had falls prior to move in, however, had not fallen since their arrival to the home.

In separate interviews with Recreation Aide #114, Personal Support Worker (PSW) #119, Registered Practical Nurse (RPN) #106, Physiotherapist (PT) #109, and Exercise Therapist #113, they all stated that resident #001 had multiple falls while in the home, and a variety of interventions had been implemented or trialed related to falls prevention.

In an interview with RPN #118, when asked the process for completing RAI-MDS assessments and RAPs, RPN #118 stated they were completed by the registered staff by looking at recent information in the chart and PointClickCare (PCC) regarding the resident. When asked if the expectation in the home is that the information in the RAI-MDS assessments and RAPs is consistent with other assessments and an accurate representation of the care for the resident, RPN #118 stated yes.

In an interview with Assistant Director of Care (ADOC) #111, when asked about the expectation for completing RAI-MDS assessments and RAPs, ADOC #111 stated that the information in the assessment should be the most current based on the seven-day look-back period, and that the assessment was meant to be collaborative. When asked if the sections of the RAI-MDS assessment and RAP, on a specified date, related to falls for resident #001 was consistent with and complemented other falls assessments completed for resident #001, ADOC #111 stated no.

The licensee failed to ensure that the staff involved in the care of resident #001 collaborated with each other in the assessment of the resident so that the assessments related to falls prevention were consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident’s substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

Complaint IL-72321-LO was submitted to the Ministry of Long Term Care (MOLTC) regarding a number of care concerns of resident #001. The concerns included medication, and Power of Attorney (POA) notification concerns.

A review of the home's policy “Physician’s Orders”, number 05-08, indicated staff were to

ensure the resident and/or POA were notified of physician orders, appointments, and any changes to medications.

In a record review of resident #001's paper chart, the Power of Attorney for Personal Care papers, stated resident #001 appointed Power of Attorney (POA) #120 as attorney for personal care.

In a record review of resident #001's paper chart, a document titled "Physician's Digiorder", included an order placed on a specified date for a specific medication. The "Notified POA/Resident" section of the order stated a message was left for the POA.

In a record review for resident #001, a progress note documented the same day as the order was placed stated specified interventions were discussed with POA #120. The progress note included no documented indication that the specified medication order was discussed with and agreed to by POA #120.

In a review of the electronic Medication Administration Record (eMAR) for resident #001, the specified medication was administered the same day the order was placed.

A review of a progress note documented three days after the specified medication was ordered for resident #001 stated the POA was concerned related to the new medication. A progress note documented four days after the specified medication was ordered stated POA #120 had concerns about the new specified medication, they felt it was too strong, and wanted the order discontinued. Five days after the specified medication was ordered a progress note documented stated POA #120 arrived to the home very emotional, stating they wanted the specified medication discontinued. A progress note documented six days after the specified medication was ordered stated an email was sent to Nurse Practitioner (NP) #112 to inform them that POA #120 does not want resident #001 to receive the specified medication.

In an interview with Registered Practical Nurse (RPN) #106, when asked what the process was regarding obtaining consent from a POA for a new medication or medication change, RPN #106 stated the physician or NP would write the order, may speak with the family and if not the registered staff would call and let the family know about the order. RPN #106 indicated that if the family stated they did not want the change, they leave it up to the physician and the family to reach an agreement.

In an interview with RPN #118, when asked if a voice message left for the POA regarding

a new medication would be considered sufficient notification, RPN #118 stated if they had to leave a voice message they would try calling again, try contacting other family members, and also let the next shift know that the POA was not reached.

In an interview with Nurse Practitioner (NP) #112, when asked if there were any discussions with POA #120 regarding the specified medication order for resident #001, the benefits and risks, and any alternative options, NP #112 stated there was no discussion prior to administering the medication. When asked whose responsibility it was to speak with the POA regarding the medication order, NP #112 stated the nursing staff would contact the POA. When asked if it would be sufficient to leave a message with a POA, NP #112 stated to their knowledge, staff need to speak with the POA directly rather than leaving a message.

In an interview with Assistant Director of Care (ADOC) #111, when asked what the process was regarding notifying a POA of a new medication, ADOC #111 stated they have to notify the POA before ordering any new medication.

In an interview with acting Director of Care (DOC) #101, when asked what the process was regarding notifying a POA of a new medication, DOC #101 stated the staff contact the POA through the process to complete first and second check after the order is written by the physician, which includes contacting the POA to get approval for the medication. When asked if it would be sufficient to leave a message with a POA, DOC #101 stated not usually. When asked if there were any discussions with POA #120 regarding the specified medication order for resident #001, the benefits and risks, and any alternative options prior to administering the medication, DOC #101 stated they were unsure, and indicated that when the nursing staff call the POA they should be discussing what the medication is used for and why they want to start it.

The licensee failed to ensure that resident #001’s substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident’s plan of care related to the use of a specified medication. [s. 6. (5)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

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 has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put any policy in place, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1, the licensee was required to have a falls prevention and management program to reduce the incidents of falls and the risk of injury.

Specifically, staff did not comply with the licensee's "Falls Prevention & Management"

policy (#04-29, last revised August 2019), which was part of the licensee's Falls Prevention and Management program and indicated the purpose of the program was to ensure everyone involved in the resident's care, including the resident's family were aware of risks, falls, and interventions in place.

Complaint IL-72321-LO was submitted to the Ministry of Long Term Care (MOLTC) regarding a number of care concerns including falls prevention and management of resident #001.

A review of the home's policy "Falls Prevention & Management", number 04-29, last revised August 2019, indicated the goal of the Falls Prevention Program was to improve resident safety by reducing the number of incidents and severity of resident falls in the village. The policy stated the goal would be accomplished using an inter-professional approach, increasing awareness of team members, residents, and their families. The policy further stated the purpose of the program was "to ensure everyone involved in the resident's care (team members, residents, and their family), are aware of potential risks, any falls, and the interventions in place".

In a record review of resident #001's paper chart, the Power of Attorney (POA) for personal care papers, stated resident #001 appointed POA #120 as attorney for personal care.

In a clinical record review of resident #001's progress notes and falls assessments in Point Click Care (PCC), it identified that resident #001 sustained falls on a number of specified dates.

A review of the post-fall assessment form identified a section to document the POA or family member notified of the fall, along with the date and time contacted. The assessment for the fall of resident #001 on a specified date, stated the fall occurred at a specified time. The assessment further indicated the POA was notified of the fall at a specified time, four hours before the fall had occurred. A progress note documented two days after the fall stated the POA was in that evening and aware of a specified symptom on resident #001, was emotional and upset, and Registered Practical Nurse (RPN) #121 explained the specified symptom was possibly related to a previous fall. There was no further documented indication that POA #120 was notified of resident #001's fall on the specified date, prior to two days following the fall.

The assessment for the fall on a second specified date, stated "Will inform oncoming

team to notify POA". A progress note documented on the second specified date noted a non-POA family member of resident #001 was notified of the fall. There was no documented indication that POA #120 was notified of resident #001's fall on the second specified date.

Assessments for four additional falls on specified dates indicated the POA was to be notified of each of the falls. There was no documented indication that POA #120 was notified of resident #001's four additional falls.

In separate interviews with Recreation Aide (RA) #114, Personal Support Worker (PSW) #119, Registered Practical Nurse (RPN) #106, Physiotherapist (PT) #109, and Exercise Therapist #113, they all stated that resident #001 had multiple falls while in the home. In an interview with RA #114, when asked about contacting the POA after a fall, RA #114 stated the registered staff have to contact the POA following a fall, to inform them of the fall and what interventions are being implemented. When asked who resident #001's POA was, RA #114 stated POA #120.

In an interview with RPN #106, when asked what the expectation was in the home regarding contacting the POA following a fall, RPN #106 stated they usually contacted the POA on that shift, depending on the time of the fall. RPN #106 further stated if the fall occurred on the night shift and there were no concerns, they would call the following day. RPN #106 indicated that the post-falls report identified who had been contacted. When asked who resident #001's POA was, RPN #106 stated POA #120. When asked if resident #001's POA was contacted following the fall they sustained on a specified date, RPN #106 stated the post-fall documentation indicated there was a discrepancy with the time of notification as it indicated the POA was notified before the fall occurred.

In an interview with Registered Nurse (RN) #107, when asked what the process in the home was related to contacting a POA after a fall, RN #107 stated that the POA was contacted immediately after a fall unless there were special instructions to call the POA on the next shift.

In an interview with Neighbourhood Coordinator (NC) #105 when asked about the fall of resident #001 on a specified date, and contacting the POA, NC #105 stated it did not make sense that the contacted time was before the time of the fall and it may have been a documentation error.

In an interview with Assistant Director of Nursing (ADOC) #111, when asked if the falls

policy indicated that a POA was to be involved in care decisions and notified of any falls, ADOC #111 stated yes. When asked about the expectation for notifying a POA of a fall, ADOC #111 indicated the expectation was that the POA was notified immediately following a fall, unless the fall occurred during the night and there were no injuries, the POA would be notified the following day. ADOC#111 stated it was a mandatory expectation that staff would contact the POA following a fall. When asked if resident #001's POA was notified of falls that occurred on a number of specified dates, ADOC #111 indicated there was no documented indication that the POA was notified of the falls as soon as possible.

The licensee failed to ensure that the home's policy for Falls Prevention and Management was complied with related to notification of POA #120 following falls of resident #001. [s. 8. (1) (a),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 where the Act or 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 plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #3: 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,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was provided with a range of continence care products that were based on their individual assessed needs.

Complaint IL-72321-LO was submitted to the Ministry of Long Term Care (MOLTC) regarding a number of care concerns of resident #001. Inspector #731 spoke with the complainant and further concerns were brought forward related to continence care.

A review of the home's policy “Continence Program”, number 04-29, indicated the goal of the program was to use assessment tools, product selection and individualized resident specific care plan support actions to maintain the resident’s level of continence and minimize deterioration or unwanted effects. The policy stated upon move-in, each resident would have a continence assessment, may include a “Voiding & Bowel Elimination Record” to determine patterns over a two-day period, and the results will be used to create a plan of action and individualized care plan. The policy indicated that the resident’s continence will be reassessed quarterly on the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessment, annually on the continence assessment, and as needed if there are changes to continence status. The policy further stated that care plans will be updated to show the type of product and size of product in use.

A clinical record review of resident #001’s RAI-MDS assessment from a specified date identified that resident #001 was occasionally incontinent of bladder and used a specified intervention. The RAI-MDS assessment from a second specified date indicated resident #001’s Activities of Daily Living (ADL) function had a deteriorated in the 90 days since the last assessment. The assessment further indicated resident #001 was incontinent of bladder and used a specified intervention.

In a record review of resident #001’s continence assessments in PoinClickCare (PCC), the only documented continence assessment completed for resident #001 was completed on admission.

In a record review of resident #001’s most recent care plan, under the focus “Bladder function”, it stated specified interventions for resident #001 related to continence. Under the focus “Toileting”, it stated a voiding diary was to be completed for a specified number of days and the intervention was initiated on a specified date. A review of the paper chart for resident #001 identified that there was no documented indication a voiding diary was

completed.

In an interview with PSW #115 when asked what the expectation in the home was for assessing a resident's continence, PSW #115 stated the registered staff members completed continence assessments. PSW #115 stated a voiding diary would usually be completed when the resident was admitted to the home and when there was a change to continence status. PSW #115 further indicated that the PSWs completed the voiding diaries and they were a paper document that went into the report book, and then into the resident's chart. When asked about the process when a resident's continence status changes, PSW #115 stated a voiding diary was usually completed to determine if a change in product was needed. In separate interviews with PSW #115 and PSW #116, when asked about resident #001's continence status, they both stated resident #001 was incontinent of bladder, and that their continence care needs changed while they were in the home. When asked what interventions resident #001 received related to continence, both PSW #115 and PSW #116 stated resident #001 was first using one specified intervention when they arrived to the home, but switched to using a different intervention.

In an interview with RPN #106, when asked how a resident's continence status was determined on admission, RPN #106 stated a voiding diary and a continence assessment was completed within the first few days of admission. RPN #106 indicated residents were re-assessed quarterly or as needed. RPN #106 stated the continence assessment was completed in PCC, and the voiding diary was a paper document completed on admission and if there was a change in continence status, that would be handed into the continence lead, ADOC #117, once completed. When asked about resident #001's continence status, RPN #106 stated resident #001 declined during their time in the home and they would assume that with their decline, their continence needs would have also changed. RPN #106 indicated that when resident #001 arrived to the home they were able to actively participate in care, however, prior to discharge, their needs had changed. RPN #106 further stated that a specified intervention was an appropriate product when resident #001 was mobile, but once their mobility status declined, it was no longer an appropriate product. When asked if an assessment was completed related to the change in continence status, RPN #106 stated according to the documentation, resident #001 only had a continence assessment completed when they first arrived to the home. RPN #106 stated a paper copy may have been completed and provided to ADOC #117 or placed into resident #001's paper chart. RPN #106 further indicated a voiding diary should have been completed according to the care plan. When asked about the care plan for resident #001 related to a change in continence product, RPN #106 indicated the care plan should have been updated.

In an interview with Assistant Director of Care (ADOC) #111, when asked how a resident's continence status was determined on admission, ADOC #111 stated the home previously completed a voiding diary, however recently they were only completed on a situational basis, and the voiding diary is a paper document. ADOC #111 stated a continence assessment was completed in PCC based on the documentation in Point of Care (POC). ADOC #111 indicated the care plan is developed based on the continence assessments and updated with any further changes. When asked if a voiding diary was completed for resident #001, ADOC #111 stated they were unable to locate a voiding diary. When asked if it should have been completed, ADOC #111 indicated yes.

In an interview with acting Director of Care (DOC) #101 when asked about the process for a change in continence status, DOC #101 stated the PSWs would have completed a change in product form and submitted the form to ADOC #117, the continence lead.

In an interview with Assistant Director of Care (ADOC) #117, when asked how a resident's continence status was determined on admission, ADOC #117 stated they looked at admission papers, the RAI-MDS, conducted interviews with the family, reviewed the TENA portraits, and completed a voiding diary. ADOC#117 stated they trial the lightest product applicable and go up from there if needed. When asked how often residents were re-assessed for their continence, ADOC #117 stated if there is a significant change in health status or if the team is requesting a change. ADOC #117 indicated there was a continence lead on each neighbourhood and that the home switched to TENA products in August 2019. When asked about completing a voiding diary ADOC #117 indicated they were completed for every resident and went into the paper chart. ADOC #117 stated they would expect the staff to let them know if there was a concern or the current product for a resident was not appropriate. When asked about the process for changing a resident to different continence product, ADOC #117 stated the team would request a product, the lead would fill out a request form, and a five-day voiding diary may be completed to determine if the request was appropriate. When asked about resident #001's continence status, ADOC #117 stated a specified intervention was implemented when resident #001 arrived to the home. ADOC #117 stated they did not recall if resident #001's continence status changed while in the home, that the RAI-MDS assessment would often trigger an assessment, and that the TENA sheet was a working document, thus there was no documentation to confirm the products resident #001 used while in the home. ADOC #117 indicated they would have expected to receive a request for a change in continence product, a continence assessment to be completed, and an updated care plan. ADOC #117 further stated the specified intervention in resident

#001's care plan was not meant for full bladder release, it was meant for light leakage.

The licensee failed to ensure that resident #001 was provided with a range of continence care products that were based on their individual assessed needs. [s. 51. (2) (h) (i)]

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 residents are provided with a range of continence care products that are based on their individual assessed needs, to be implemented voluntarily.

Issued on this 10th day of February, 2020

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

Original report signed by the inspector.