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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 16, 2020 | 2020_533115_0020 | 014718-20, 016866-20, 017485-20, 018560-20, 018893-20, 019095-20, 020744-20 | 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

TERRI DALY (115), CASSANDRA TAYLOR (725), CHRISTINA LEGOUFFE (730)

## 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 20, 21, 22, 23, 26, 27, 28 and 29, 2020.**

**The following Critical Incident intakes were completed within this inspection:**

**Related to falls prevention:**
**Critical Incident Log #014718-20 / CIS #3046-000048-19.**

**Related to an incident that results in a significant change in the resident's health status:**
**Critical Incident Log #016866-20 / CIS #3046-000055-20;**
**Critical Incident Log #018560-20 / CIS #3046-000060-20;**
**Critical Incident Log #018893-20 / CIS #3046-000061-20;**
**Critical Incident Log #020744-20 / CIS #3046-000069-20.**

**Related to Unexpected Death:**
**Critical Incident Log #019095-20 / CIS #3046-000063-20.**

**This inspection also included a Follow Up Inspection related to Compliance Order #001 from Inspection #2020_533115_0014, Log #017485-20 related to a lingering offensive odour.**

**During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Facilities, the Director of Nursing Care (DNC), the Director of Environmental Services, an Assistant Director of Nursing Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Housekeeping Aide (HA), the Kinesiologist and residents.**

**The inspector also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents,**
**and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Falls Prevention**
**Hospitalization and Change in Condition**

**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)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 87. (2) | CO #001 | 2020_533115_0014 | 115 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the staff involved in the different aspects of care for resident #005 collaborated with each other, in the assessment of the resident so that the assessments are integrated and were consistent and complemented each other.

Resident #005 was admitted to the home on a specific date. During the initial assessment the resident showed signs and symptoms of a potential injury as documented by Kinesiologist #115 and Registered Practical Nurse (RPN) #114. Documentation indicated the resident expressed specific signs and symptoms for a specific time period. On a certain date, RPN #114 had documented that the resident had a possible condition and the physician would be in to assess. An x-ray was ordered by the physician and was completed, it indicated that the resident had a specific injury/condition and they were transferred to the hospital. RPN #114, #117, RN #118 and the General Manager indicated that if a resident was displaying signs and symptoms as resident #005 was, that the physician should be contacted for assessment immediately.

When staff did not collaborate with each other, in their assessment there was potential for risk of harm as interventions could have been initiated sooner.

Sources: Resident #005's progress notes, assessments, x-ray reports and RPN #114,

#117, RN #118 and Kinesiologist #115 staff interviews. [s. 6. (4) (a)

2. The licensee has failed to ensure that different approaches were considered in the revision of the plan of care for resident #001.

On review of the documentation it indicated that between a specific time frame resident #001 had had a number of incidents During staff interviews with Personal Support Workers (PSWs) #119 and #120 both indicated that the resident was a risk and interventions were in place. During a record review there was no documentation to indicate that interventions were reviewed or different approaches were trialed. The Assistant Director of Nursing Care (ADNC) #110 confirmed, that the different interventions and trials were not documented. Personal Support Worker (PSW) #119 stated that the interventions prevented some injuries however the resident continued to have incidents.

Not reviewing and revising the plan of care to ensure different approaches are considered provided for a potential risk of harm.

Sources: Staff interviews PSW #119, #120 and ADNC #110, Resident #001's care plan, relevant progress notes and assessments. [s. 6. (11) (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 the plan of care is a collaborative assessment, that is integrated, consistent and that complements each other; that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any actions taken with respect to resident #001 under the falls prevention program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

During record review, resident #001 was identified as a specific risk and had had several incidents documented between a specific time frame. Review of the progress notes indicated that the resident was seen by the staff team on a specific date. At which time interventions were documented to be trialed. During an interview it was indicated by the Assistant Director of Nursing Care (ADNC) #110 that the resident was followed by this team, however there was no documentation relating to the assessment, implementation and evaluation of the interventions.

Not documenting the assessments, reassessments, interventions and the resident's responses to interventions provided a potential risk of harm as there was no documentation to follow up on.

Sources: Resident #001 progress notes, care plan, assessments and staff interview with ADNC #110. [s. 30. (2)]

***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 actions taken with respect to a resident, under the falls prevention program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, 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 has failed to ensure that resident #001's written records were kept up to date at all times.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) for resident #001. During record review a progress note was written by RPN #108 indicating that the resident was experiencing some difficulties, with no follow up assessment and hours later the resident had died. Review of the home's internal investigation notes indicated that the resident had had a previous incident on a specific date, with a specific injury. During staff interviews with RPN #108 they indicated that they had charted incorrectly, and they did not go back and make a late entry. RPN #108 also indicated that the resident did have an assessment completed, the RPN stated that the Charge Nurse (CN), Registered Dietitian (RD) and Physician had been to see the resident. Upon further record review there was no documentation from the CN or RD. Both the CN Registered Nurse (RN) #111 and RD were interviewed, and both confirmed they had seen the resident and did not document. The death certificate was completed by the corner and reviewed. The residents cause of death was determined to be from a pre-existing condition unrelated to the incident.

Not keeping records up to date at all times could present a potential risk of harm as assessments and treatments could be missed.

Sources: CIS report, Resident #001 progress notes, assessments, the home's interval investigation notes, Staff interviews with RPN #108 , RN #111 and RD # 123. [s. 231.]

***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 written records are kept up to date at all times, to be implemented voluntarily.***

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**Issued on this 17th day of November, 2020**

[redacted]

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

**Original report signed by the inspector.**