Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Original Public Report

Report Issue Date: November 27, 2023

Inspection Number: 2023-1399-0007

Inspection Type:
Complaint
Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Riverside Glen, Guelph

Lead Inspector	**Inspector Digital Signature**
Kaitlyn Puklicz (000685)	Kaitlyn Joan Puklicz Digitally signed by Kaitlyn Joan Puklicz Date: 2023.12.08 10:58:14 -05'00'

Additional Inspector(s)
Dianne Tone (000686)
Craig Michie (000690)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 1-3, 6-8, 2023.

The following intake(s) were inspected:

- Intake: #00091662 - Physical abuse of a resident by another resident.
- Intake: #00097794 - Physical abuse of a resident by staff.
- Intake: #00100435 - Complaint related to assessments and pain control measures.

The following intakes were completed in this inspection: Intake #00098974 and Intake #00096624 were related to falls.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC # 001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible.

The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible.

Rationale and Summary
Staff were assisting a resident with their care.

Staff did not follow the resident's plan of care when they had three staff members provide care while the resident was resistive. The resident became verbally and physically responsive and staff also did not follow the plan of care for responsive behaviours. One of the PSWs used physical force towards the resident.

A neighborhood coordinator (NC) #107 said that staff did not follow the stop and re-approach technique when the resident became expressive and uncooperative with their care.

By not implementing the resident's responsive behaviour strategies, the resident was at risk of injury.

Sources: Clinical record for the resident, the home's investigative notes, interview with NC #107.

[000685]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from abuse.

Rationale and Summary
A resident had an altercation with another resident resulting in injury.

This incident of physical abuse caused moderate impact to the resident as they experienced pain and injury as a result of the incident.

Sources: CIR #2915-000032-23, clinical record for the residents.

[000685]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an incident of physical abuse towards a resident was reported to the Director immediately.

In accordance with FLTCA, 2021, s. 154 (3), the licensee is vicariously liable for a staff member failing to comply with subsection 28 (1).

Rationale and Summary
An allegation of physical abuse was reported by a staff member to NC #107, 15 days after it occurred. The incident was then reported to the Director.

Investigative interview notes demonstrated that two staff witnessed the alleged abuse and neither of them reported it at the time of the incident.

NC #107 stated that staff should have reported the alleged abuse on the day it occurred, and that the staff member who the allegations were against continued providing care to residents until the investigation was initiated.

When the staff who witnessed the alleged abuse did not report the incident immediately, this allowed the staff member to continue providing resident care and delayed the Director's ability to respond to the incident in a timely manner.

Sources: CIR #2915-000047-23, clinical record for the resident, the home's investigative notes, interview with a NC #107.

[000685]

WRITTEN NOTIFICATION: General requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (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.

The licensee has failed to ensure that actions taken for a resident with respect to the home's falls program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary
A resident had an assisted fall to the floor by staff. The Home's Fall Prevention and Management Program stated that if a resident is lowered to the floor with the assistance of team members, it should be recorded as a fall.

A Registered Practical Nurse (RPN) stated that they did not document the Fall's Incident on the date of the fall. Instead, the Fall Incident was documented four days later. As a result, the falls assessments were not completed at the time which may have impacted resident care.

The AGM stated that the expectation is for a falls incident report to be completed at the time of the fall. They stated that due to the Falls Incident not being documented, two assessments were missed following the fall.

The home's failure to document the post fall assessment in the Falls Incident at the time of the fall could have delayed early identification of pain or injury.

Sources: Fall Prevention and Management Program, Falls Policy, Progress Notes, SV - Falls Incident, Interviews with an RPN and the AGM.

[000690]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe

transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a resident was transferred safely by staff.

Rationale and Summary
A resident was lowered to the floor with the assistance of team members.

The resident was then manually transferred by three team members back into their wheelchair.

The AGM stated that there is a no manual lift policy for the home and that if a resident is unable to get off the floor by themselves or with additional support from one staff then a mechanical lift is required.

When the resident was manually transferred by staff they were at risk of injury.

Sources: Transfer Status Assessment Guide Policy, Fall Prevention and Management Program policy, Interviews with an RPN, PSW and the AGM.

[000690]