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: February 29, 2024
Inspection Number: 2024-1399-0001
Inspection Type: Proactive Compliance Inspection
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Riverside Glen, Guelph

Lead Inspector	**Inspector Digital Signature**
Diane Schilling (000736)	Diane Schilling Digitally signed by Diane Schilling Date: 2024.03.19 13:35:36 -04'00'

Additional Inspector(s)
Brittany Nielsen (705769)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 8- 9, 12-16, 20-21, 2024

The following intake(s) were inspected:

- Intake: #00108520 - Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Posting of information

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 85 (3) (q)

Posting of information

s. 85 (3) The required information for the purposes of subsections (1) and (2) is,

(q) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;

The licensee failed to ensure that the following required information was posted in the home: the most recent minutes of the Family Council meetings.

Rationale and Summary

No Family Council Meeting minutes were posted on the bulletin board.

The Assistant General Manager (AGM) stated Family council were still having meetings, but the LTCH had not received a copy of the meeting minutes since May 2023.

There was a potential risk of families not being informed about topics discussed during family council meetings when the minutes weren't posted.

Sources: Observations, interviews with staff
[000736]

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that the soiled utility room doors on Mapleton, Arthur, and Erin Neighbourhoods were kept closed and locked when the room was not supervised by staff.

Rationale and Summary
The doors to the soiled utility rooms on several Neighbourhoods were observed to be unlocked.

Two Registered Practical Nurses (RPN's) said the soiled utility room doors were to be kept locked at all times.

When the doors on several Neighbourhoods were found to be unlocked, there was

a potential risk to residents when they had access to an unsupervised area.

Sources: observations, interviews with staff
[705769]

WRITTEN NOTIFICATION: Food production

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The licensee failed to ensure that all food and fluids in the food production system were served using methods to prevent adulteration, contamination, and food borne illness.

Rationale and Summary:
A staff member provided a resident with a cup that was in contact with dirty dishes.

The Director of Nursing Care (DOC) said they should have provided the resident with a clean cup.

By providing a resident an item that was in contact with unclean items from co-residents, there was risk of contamination.

Sources: observations, interviews with staff
[705769]

WRITTEN NOTIFICATION: Food Production

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee shall ensure a process is in place to ensure that food service workers and other staff assisting residents are aware of the resident's diet and special needs.

Rational and Summary
A resident's care plan specified a particular diet.

The resident was observed not getting their specified diet.

A dietitian confirmed that the resident's prescribed diet was not what they were served.

The resident was at risk of choking when given the incorrect diet texture during their meal.

Sources: Observations, residents' clinical record, interviews with staff [000736]

WRITTEN NOTIFICATION: Dining and snack service

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee failed to ensure that residents were provided with any eating aids, assistive devices and personal assistance and encouragement to safely eat and drink as comfortably as independently as possible.

Rationale and Summary
A resident was not provided the assistive devices and assistance that was stated on their care plan.

The Neighbourhood Coordinator (NC) said the resident should been provided with assistance and an assistive device to increase independence.

Sources: observations, interviews with staff and resident clinical record.
[705769]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that staff disposed of used personal protective equipment (PPE) correctly when exiting a room on additional precautions.

According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated April 2022, section 9.1 directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program, specifically 9.1 (d) referring to proper use of PPE, including appropriate selection, application, removal, and disposal.

Rationale and Summary:
Inspector #705769 observed an RPN exiting a resident room while wearing PPE. The staff member did not discard their PPE properly and no hand hygiene was performed prior to donning new PPE.

The DOC said the used PPE should have been discarded in the garbage inside the resident's door.

By not discarding the used PPE correctly, there was risk for transmission of infectious agents.

Sources: observations, interviews with staff
[705769]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)

Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

The licensee failed to ensure that staff followed the home's Managing a Respiratory Outbreak policy, while the Puslinch Neighbourhood was in a COVID-19 outbreak.

As per O. Reg. 246/22, s. 11 (1) (b), the licensee shall ensure that where the Act or Regulations required the licensee of a long-term care home to have, institute, or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

The home's Managing a Respiratory Outbreak policy stated to close the fire doors to the entrance of Neighbourhoods in outbreak.

Rationale and Summary:
The fire doors to Puslinch Neighbourhood were open for approximately 1.5 hours. Puslinch Neighbourhood was in a confirmed COVID-19 outbreak at the time.

The IPAC Lead said the doors should have been closed at that time.

Sources: observations, interviews with staff and record review of the home's Managing a Respiratory Outbreak policy.
[705769]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.

Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

A) Specifically in falls prevention and management

Rationale and Summary
According to training records for Fall prevention and Management, five staff were overdue in completing their annual training for 2023.

The Fall prevention lead acknowledged that annual training was mandatory.

Failure to train direct care staff in falls prevention and management, on an annual basis, increased the risk that residents would not receive the most up-to-date and relevant approaches for falls prevention and management.

Sources: Training records and interviews with staff
[000736]

B) Pain Management, including pain recognition of specific and non-specific signs of pain.

Rationale and Summary
According to the training records for Managing Pain and Distress, in 2023, five staff were overdue in completing their annual training.

The Pain lead acknowledged that annual training was mandatory.

Failure to train direct care staff in Managing Pain and Distress, on an annual basis, increased the risk that residents would not receive the most up-to-date and relevant approaches for Management Pain and distress.

Sources: Training records, Review of license policy titled, "Pain Policy", and interviews with staff
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