Ontario

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

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

Central West District
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Original Public Report

Report Issue Date: October 11, 2024
Inspection Number: 2024-1399-0004
Inspection Type: Critical Incident
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Riverside Glen, Guelph

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 10-13, 16-20, 23, 2024
The inspection occurred offsite on the following date(s): September 12, 2024
The following intake(s) were inspected:
Intake: #00123508 - CI #2915-000022-24 - Related to behaviour resulting in a fall.
Intake: #00123594 - CI #2915-000023-24 - Related to resident to resident abuse.
Intake: #00124817 - CI #2915-000024-24 - Related to resident to Resident abuse.
Intake: #00124942 - CI #2915-000026-24 - Related to a fall.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: General Requirements

NC #001 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 failed to ensure that the documentation was completed for residents.

Rationale and Summary
A) A resident was documented to have verbal, physical and socially inappropriate behaviours.

A Physician ordered: continue DOS (Dementia Observation System) for 1 week every shift for 7 days.

Personal Expression Response Team (PERT) lead stated DOS is used and completed by staff on neighbourhood.

The DOS was missing several instances of documentation.

A Physician documented that DOS is incomplete and some incorrect documentation.

Rationale and Summary
B) A resident was documented to have aggressive behaviours that were triggered by co-residents entering their room uninvited.

A resident entered that resident's room and there was altercation between the two residents.

Dementia Observation System tool was initiated and documentation was incomplete.

Rationale and Summary
C) A resident was documented to have an altercation with another resident.

Dementia observation system tool was initiated. The DOS was not completed.

Rationale and Summary
D) A resident was documented to have an altercation with another resident.

Dementia observation system tool was initiated but the documentation was incomplete.

Failure to complete the Dementia Observation System tool may delay in appropriate response and treatment of residents' behaviours.

Sources: Residents' clinical records, DOS tools

WRITTEN NOTIFICATION: Pain Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument.

Rational and summary:
A resident had a fall that resulted in the resident having pain.

PAINAD score was documented as pain score increasing.

Pain medication administration was documented on the electronic Medication Administration Record as being administered three times but then not again for several hours.

Two staff stated they did not recall completing pain assessments.

The home's failure to assess the resident using a clinically appropriate assessment instrument specifically designed for this purpose put the resident at risk of pain for an extended period of time.

Sources: Resident's clinical records, Interviews with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The Licensee failed to follow the physician's order to when a resident exhibited any physical expressions towards staff or residents.

Rationale and Summary:
A resident was known to exhibit behaviours of physical expression towards others.

A Physician ordered: Call MD stat if resident exhibits any physical expressions towards staff or residents and continue DOS for 1 week every shift for 7 days

The Personal Expression Response Team (PERT) lead stated that the DOS was to be completed by PSWs.

A staff member stated there was an order to notify the Physician when the resident exhibited physical expressions of behaviour towards others.

Resident DOS documentation identified hitting and aggression.

A Physician documented that DOS was incomplete and they were not notified of behaviours STAT when they occurred.

When the Licensee failed to notify the Physician right away of a resident's abusive behaviours it could have delayed the physician from providing timely interventions of treatment.

Sources: Resident clinic record, interview with staff.

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents when interventions were not implemented as documented for a resident.

Rationale and Summary:
A) A resident sustained an injury when they wandered into another resident's room.

A resident was known to have territorial behaviours related to others entering their room.

A resident's plan of care interventions were not implemented.

Staff stated that these interventions would have prevented another resident from entering the other resident's space.

When interventions were not followed for a resident, another resident sustained injuries.

Rationale and Summary:
B) A resident was known to have territorial behaviours.

The resident plan of care interventions were not implemented.

Staff stated that these interventions would have prevented another resident from entering the other resident's space.

When a resident wandered into another resident's personal space and that resident tried to have them leave, there was an altercation, and the resident was injured.

When resident's plan of care was not followed, they sustained injuries when they engaged in a physical altercation.

Sources: Residents' clinical records, staff interview.

WRITTEN NOTIFICATION: Reports re: critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (6)
Reports re critical incidents
s. 115 (6) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 246/22, s. 115 (6).

The licensee failed to ensure that resident's substitute decision-maker was promptly notified when they fell and were injured.

Rationale and Summary:
A resident had a fall with unrelieved pain despite pain medication being administered.

Staff documented they did not notify the Power of Attorney (POA).

Staff stated they did not call the POA as they were busy and didn't think to call.

Staff stated they notified the Power of Attorney of the incident several hours later, after assessing the resident, at which time the POA agreed to have resident go to hospital.

When the Power of Attorney was not notified of a resident fall and condition promptly it may have delayed resident treatment.

Sources: Resident clinical record, interviews with staff, email communication.