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

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Original Public Report

Report Issue Date: December 21, 2022	
Inspection Number: 2022-1366-0002	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Erin Meadows, Mississauga	
Lead Inspector Wing-Yee Sun (708239)	**Inspector Digital Signature** Wing Yee Sun 2023.01.04 11:43:33 -05'00'
Additional Inspector(s) Rajwinder Sehgal (741673)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 23-25, 28-30, December 1-2, 2022

The following intake was completed in this complaint inspection:
Intake #00014195 related to alleged abuse.

The following intakes were completed in this Follow up inspection:
Intake #00013909 and Intake #00014037 were related to Infection Prevention and Control (IPAC) Program.

The following intake was completed in this Critical Incident System (CIS) inspection:
Intake #00013868 related to alleged abuse and improper transferring and positioning technique.

Previously Issued Compliance Orders

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O.Reg. 79/10	s. 229 (4)	2022-780699-0004	#001	Rajwinder Sehgal (741673)

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O.Reg. 246/22	s. 102. 2 (b)	2022-1366-0001	#001	Rajwinder Sehgal (741673)

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

Infection Prevention and Control
Resident Care and Support Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #01 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that there was a hand hygiene program in place in accordance with any standard issued by the Director.

Specifically, IPAC Standard for Long-Term Care Homes, s. 10.1 stated that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary

(i) During an observation, it was noted that the Alcohol Based Hand Rub (ABHR) in a therapy room was expired.

A staff acknowledged that the ABHR was expired. They immediately removed the bottle of expired ABHR and replenished it with a new bottle.

The IPAC Lead acknowledged that they were informed of the expired hand sanitizer bottles and confirmed that all expired bottles were removed from the home.

Sources: Observations, and interviews with a staff and the IPAC Lead.

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Date Remedy Implemented: November 23, 2022

The licensee has failed to ensure that their hand hygiene program was implemented in accordance with any standard issued by the Director.

Rationale and Summary

(ii) Two bottles of expired ABHR were found on a resident home area. A staff was observed assisting residents with hand hygiene using the expired product.

A Registered Practical Nurse (RPN) acknowledged that the ABHR was expired, immediately discarded the product and replaced them. They acknowledged that expired ABHR could have decreased effectiveness against pathogens and infection control.

Sources: Observations, and interview with a RPN.

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Date Remedy Implemented: November 23, 2022

WRITTEN NOTIFICATION: Written Notification

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (a)

The licensee has failed to ensure any surveillance protocols related to Rapid Antigen Test (RAT) issued by the Director for a particular communicable disease or disease of public health significance were complied with.

Rationale and Summary

Observations of the home's IPAC practices related to RAT identified that three visitors and a Tester, did not follow the manufacturer's instructions of the RAT device on an identified date.

The home used Abbott Panbio: COVID-19 Ag, Rapid Test Nasal Device to conduct surveillance testing. The manufacturer's instructions indicated to rotate the swab five times against the nasal wall in both nostrils, swirl the swab tip in the buffer fluid inside the extraction tube at least five times and read result at 15 minutes. A Tester and three visitors failed to follow all three steps as per manufacturer's directions.

The Tester acknowledged that the manufacturer's instructions related to testing procedure were not followed to ensure accuracy of the test results. The Tester did not wait minimum of 15 minutes before reading the test result for three visitors and allowed them to enter in resident neighbourhood areas.

The IPAC Lead acknowledged that the Tester did not follow the testing protocols according to manufacturer's instructions.

As a result of the home not following the RAT manufacturer's instruction, there was a risk of harm to residents, staff and visitors related to spread of COVID-19 infectious disease.

Sources: Observations on an identified date, Abbott Panbio: COVID-19 Ag, RAPID TEST DEVICE (Nasal) Booklet, interviews with a Tester, the IPAC Lead and other staff.

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WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

The licensee has failed to ensure that a resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality was fully respected and promoted.

Rationale and Summary

On an identified date, two staff members left the resident alone in bed when they were in the middle of changing the resident. The resident was not fully clothed and was exposed in bed.

A PSW acknowledged that the resident's dignity was not respected by leaving them naked and uncovered. An ADNC and the DOC acknowledged that based on the evidence, two PSWs left the resident exposed and uncovered, and the resident's Bill of Rights for dignity was not supported.

Sources: Evidence provided for an identified date; interviews with an ADNC, the DOC and other staff.

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WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe positioning techniques when assisting a resident.

Rationale and Summary

During care on an identified date, the resident's legs were dangling off the edge of the bed when they were rolled to the right side. During care staff positioned the resident's legs apart along both edges of the bed, and one staff had positioned the resident's left arm up above the resident's head and beyond their body alignment when dressing the resident.

A Neighbourhood Coordinator (NC)/Personal Support Worker (PSW) acknowledged they had concerns with the positioning of the resident's legs during care, and acknowledged it could have been an uncomfortable and scary experience for the resident. An ADNC and the DOC acknowledged that when the two staff provided care, the resident's legs should not have been dangling off the bed. The

positioning of the resident's arm appeared to be painful, and the staff used improper positioning techniques. The ADNC acknowledged there was risk of injury and risk of the resident falling from bed by not providing the correct positioning techniques. The NC/PSW and the DOC acknowledged that the staff required education on proper positioning techniques for the resident.

Sources: Evidence provided for an identified date, interviews with an ADNC, the DOC and other staff.

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WRITTEN NOTIFICATION: Pain Management

NC #05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 57 (2)

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 specifically designed for this purpose.

Rationale and Summary

Staff did not follow the home's pain management program policy when a pain assessment was not completed when the resident's family reported that there was pain present, and the resident displayed indication of pain, upon the resident's return from the hospital, and when there was pain medication initiated.

Family of the resident reported to multiple staff that pain was present upon movement of the resident's extremity on an identified date. A Medical Doctor (MD) assessed the resident and identified range of motion (ROM) of their extremity was very painful. Diagnostic imaging was ordered to rule out an injury and as needed (PRN) pain medication was ordered. PRN pain medication was administered by registered staff until the diagnostic imaging results were obtained. The diagnostic imaging results confirmed that the resident had sustained an injury. The resident was transferred to hospital on an identified date and returned with an inoperable injury.

A RPN acknowledged that the resident's family verbalized pain was present and felt that a pain assessment was appropriate for the resident, but it was not completed. An ADNC acknowledged the nurse should have completed a pain assessment if the family informed the nurse the resident was in pain. The DOC expected staff to complete pain assessments for the resident to determine the

progression of their pain. The ADNC and DOC acknowledged pain assessments should have also been completed when the MD identified pain to the resident's affected area, upon their return from hospital and when there were changes to their pain medication. Pain assessments were not completed.

Sources: The licensee's policy titled Pain Management Program – Nur 04-48, clinical records of the resident, interviews with a RPN, ADNC and other staff.

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WRITTEN NOTIFICATION: Plan of Care

NC #06 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care was provided to a resident as specified in the resident's plan of care.

Rationale and Summary

The resident required two-person total assistance for bed mobility. On an identified date, one staff repositioned the resident on their left side and then on their right side while providing care. On another identified date, one staff repositioned the resident on their left side.

A PSW, a NC/PSW and the DOC acknowledged that the resident required two-person assistance for care. An ADNC and the DOC acknowledged that staff did not provide care to the resident according to their plan of care when one staff provided care to the resident.

Sources: The resident's written plan of care, evidence provided for two identified dates, interviews with a PSW, a ADNC and other staff.

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WRITTEN NOTIFICATION: Plan of Care

NC #07 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a

resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Rationale and Summary

On an identified date, two staff were informed by family that the resident experienced pain upon movement of their extremity. Staff identified pain was present for the resident and informed family to avoid moving the resident's extremity to prevent any further injury to the area. They did not inform staff on the unit about what was observed that morning. When the MD assessed the resident later that day they were identified as having pain with ROM to the affected area, and ordered diagnostic imaging to rule out injury. The MD ordered to keep the affected area immobile due to pain.

During the provision of care, staff continued to position the resident onto the side of their body with the suspected injury.

A RPN acknowledged the resident was unable to roll on their side independently and had heard about the resident being rolled on to their affected area. An ADNC acknowledged they saw evidence confirming the resident was positioned on their affected area after the MD had assessed the resident and ordered to keep the resident's affected area immobile. Staff did not follow the MD's order. They identified that the resident may have caused pain and potentially complicated the injury further by continuing to reposition the resident to the identified side during care.

Sources: The resident's clinical records, evidence provided from an identified date, interviews with an ADNC and other staff.

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