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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: June 26, 2024

Inspection Number: 2024-1366-0002

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Erin Meadows, Mississauga

Lead Inspector	**Inspector Digital Signature**
Emmy Hartmann (748)	

Additional Inspector(s)
Barbara Grohmann (720920)
Waseema Khan (741104)
Lisa Bos (683)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 11-14, 17-19, 2024.

The following intake(s) were inspected:

- Intake: #00113684, was related to a follow-up to compliance order (CO) for Ontario/Regulations (O. Reg.) 246/22 s. 26, with a compliance due date (CDD) of April 28, 2024.
- Intake: #00113685, was related to a follow-up to CO for O. Reg. s.96 (1) (b), with a CDD of May 8, 2024.
- Intake: #00112722, was a complaint related to resident care.

- Intake: #00113582, was a complaint related to resident care.
- Intake: #00104188, Critical Incident System (CIS) #2881-000052-23, was related to an injury of unknown cause to a resident.
- Intake: #00111740, CIS #2881-000014-24, was related to an allegation of improper/incompetent treatment of a resident by staff.
- Intake: #00112588, CIS #2881-000017-24, was related to an allegation of resident to resident physical abuse.
- Intake: #00112747, CIS #2881-000018-24, was related to an allegation of sexual abuse of a resident.
- Intake: #00115734, CIS #2881-000024-24, was related to an injury of unknown cause to a resident.
- Intake: #00115798, CIS #2881-000025-24, was related to an allegation of physical abuse to a resident.

Previously Issued Compliance Order(s)

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

Order #002 from Inspection #2024-1366-0001 related to O. Reg. 246/22, s. 26 inspected by Waseema Khan (741104)

Order #001 from Inspection #2024-1366-0001 related to O. Reg. 246/22, s. 96 (1) (b) inspected by Waseema Khan (741104)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The fall focus of a resident's care plan specified that their bed would be positioned at a safe transferring height. In another another part of the care plan, the bed was to be in the lowest position.

Observations of the resident's room showed that the bed was not in the lowest position. A PSW stated that the bed in the lowest position would not be safe for the resident. They agreed that the different directions could be confusing for staff unfamiliar with the resident.

The Resident Assessment Instrument (RAI) Coordinator acknowledged that the two interventions in the resident's care plan were contradictory and that the lowest bed position may not be a safe transferring height. The RAI Coordinator changed the resident's care plan so that the two interventions were consistent with one another and appropriate for the resident.

Sources: A resident's clinical records; observations; interviews with RAI Coordinator and other staff. [720920]

Date Remedy Implemented: June 12, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that the outcomes of the care set out in the plan of care for a resident was documented.

Rationale and Summary
The home's physician wrote an order for a resident's intervention to be completed once a week. A nurse verified that the outcome of the intervention was only documented in Point Click Care (PCC), which the physician could access when determining the effectiveness of the intervention.

A review of the resident's clinical records showed that in a period of 24 weeks, only six outcomes of the intervention were in PCC.

The Assistant Director of Nursing (ADON) determined that the documentation of the outcome to the intervention was missing. The registered practical nurses (RPN) were signing the electronic medical administration record (eMAR) that the intervention was completed; however, the outcome of the intervention was not documented. The ADON verified that the RPNs were expected to document the weekly intervention was completed, and the outcome.

Failure to document the outcome of care set out in the plan of care for the resident may have resulted in the physician being unaware of the how effective the intervention was in managing their condition.

Sources: A resident's clinical records, home's investigation notes; interviews with the ADON and other staff. [720920]

WRITTEN NOTIFICATION: Nursing and personal support services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (1) (b)
Nursing and personal support services
s. 11 (1) Every licensee of a long-term care home shall ensure that there is,

(b) an organized program of personal support services for the home to meet the assessed needs of the residents.

The licensee has failed to ensure that the personal support services program to meet the assessed needs of a resident, was complied with.

Rationale and Summary
In accordance with Ontario Regulation 246/22, s. 11 (1) b, the licensee was to ensure that where the Act required the licensee of a long-term care home to have, institute or otherwise put in place any program, the licensee was required to ensure that the program, was complied with.

Specifically, the home did not comply with their Resident Contracted Private Services policy, which was a part of the personal support services program, which stated that the home required all persons and organizations providing private services to a resident in the home to sign a "Resident Contracted Services Agreement", prior to any services being rendered on-site. It also stated that private duty service providers would receive orientation to the home prior to providing services, and were required to provide proper photo identification, prior to their first visit with a resident.

The Assistant General Manager (AGM) identified that the resident had private caregivers from the day they were admitted to the home; however, they were not asked to sign the Resident Contracted Service Agreement, and to provide proper photo identification until seven months after admission to the home. They also verified that there had been no orientation to the home provided to the private care givers.

There may have been a risk to the resident when the private caregivers were not

provided orientation to the home prior to providing services to the resident.

Sources: Resident Contracted Private Services policy, the home's investigation notes; interview with the AGM. [748]

WRITTEN NOTIFICATION: Reports of investigation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee has failed to report to the Director the results of the investigation undertaken related to the suspected abuse of a resident.

Rationale and Summary
A CI report identified that a resident was sent to the hospital on an identified date, after they sustained an injury. The CI report identified that abuse was suspected. The AGM verified that abuse was not substantiated. They confirmed that the results of the investigation to the incident was not reported to the Director.

Sources: A resident's progress notes, the home's investigation Package, CI report; interview with the AGM. [748]

WRITTEN NOTIFICATION: Behaviours and Altercations

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

The licensee has failed to ensure that interventions were implemented to minimize the risk of altercations and potentially harmful interactions between a resident and their co-residents.

Rationale and Summary
A resident had a history of behaviours towards residents and had an intervention with specific directions in place.

A) On an identified date, the resident had an incident with another resident which resulted in injuries. A staff reported that the directions related to the intervention was not followed.

The Neighbourhood Coordinator acknowledged that the staff failed to implement the intervention in the resident's plan of care, which resulted in injuries to the resident.

Sources: Critical Incident (CI) 2881-000017-24; two residents' clinical records; home's investigation notes; interview with Neighbourhood Coordinator and other staff. [683]

B) On an identified date, the resident was observed without their intervention. The nurse acknowledged that the intervention should have been in place at the

time of the observation.

There was risk of altercations between residents when the resident did not have their intervention in place.

Sources: Observations; a resident's clinical record; interview with staff. [683]

WRITTEN NOTIFICATION: Notification re incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was notified of the suspicion of abuse of a resident.

Rationale and Summary
A CI report identified that the resident was sent to the hospital on an identified date, after they sustained an injury. The CI report identified that abuse was suspected. The AGM verified that the SDM was not notified of the suspicion of abuse of the resident.

There was a risk that the SDM could not participate in the development and implementation of the plan to keep the resident safe, when they were not notified

of the suspicion of abuse.

Sources: A resident's progress notes, the home's investigation package, CIS report; interview with the AGM. [748]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 109 (1)
Additional requirements, s. 26 of the Act
s. 109 (1) A complaint that a licensee is required to immediately forward to the Director under clause 26 (1) (c) of the Act is a complaint that alleges harm or risk of harm, including, but not limited to, physical harm, to one or more residents.

The licensee has failed to ensure that a complaint alleging harm or risk of harm to a resident was immediately forwarded to the Director.

Rationale and Summary
On an identified date during a weekend, a resident's SDM emailed a complaint to the home alleging harm to the resident.

The ADON acknowledged that the after hours line should have been used to report the complaint to the Director as it was received on the weekend, and since it was not, the CI report was submitted late.

Failure to send a CI within the required time frame may have resulted in the Director not being made aware of the situation and taking actions if necessary.

Sources: CI #2881-000014-24, home's email correspondence with the complaint;

interview with ADON. [720920]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 109 (2)
Additional requirements, s. 26 of the Act
s. 109 (2) For the purposes of subsection 26 (2) of the Act, the licensee shall also ensure that it provides to the Director, in a manner acceptable to the Director, a copy of the part of the documented record the licensee is required to keep under subsection 108 (2) that is related to the complaint.

The licensee has failed to ensure that it provided to the Director a copy of the documented record the licensee was required to keep under Ontario Regulations (O. Reg.) 246/22, subsection (s.) 108 (2) that was related to the complaint.

Rationale and Summary
O. Reg. 246/22 s. 108 (2) specified that for every written or verbal complaint made to the licensee or staff, a documented record was kept that included:

- the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- the final resolution, if any;
- every date on which any response was provided to the complainant and a description of the response; and
- any response made in turn by the complainant.

The home's investigation notes included email correspondence between the home and the complainant, and a response letter to the complainant. The response letter

detailed the actions the home took to address the complaint, including dates and time frames.

The correspondence related to the complaint was attached to CI #2881-000014-24, but the home's response letter and email correspondence were not. The CI failed to include all the types of actions taken to resolve the complaint including dates and time frames, the final resolution, date and description of any response provided to the complainant, and any response made in turn by the complainant.

The ADON acknowledged that the CI submitted by the home should have contained the missing information, either in the body of the CI or as an attachment.

Failure to include all the information required in O. Reg. 246/22 s. 108 (2) in the CI report may have resulted in the Director not being fully apprised of whether a complaint alleging harm was managed by the home appropriately.

Sources: CI #2881-000014-24, home's email correspondence with the complainant and response letter; interview with the ADON. [720920]