Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 19, 2022	2022_944480_0001	007089-21	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

The Village of Tansley Woods
4100 Upper Middle Road Burlington ON L7M 4W8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JENNIFER ALLEN (706480)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 6-7, 10-12, 2022.

The following intake was completed in this Critical Incident System (CIS) Inspection:
Log #007089-21, was related to Falls Prevention.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs) and residents.

During the course of the inspection, the inspector toured the home, observed resident and staff interactions, interviewed staff, reviewed clinical health records and relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for a resident relating to fall interventions was provided to the resident as specified in the plan of care.

A. A resident sustained a fall that resulted in an injury. At the time of the fall the resident's plan of care included specific interventions relating to falls. The home confirmed these interventions were not implemented at the time of the fall. The home communicated to the resident's family that the specific interventions were not in place at the time of the fall.

The Assistant General Manager further confirmed that the staff did not follow the specific interventions described in the care plan to protect the resident from falls.

B. Upon observation of a resident in bed, specific intervention relating to falls could not be located. Staff could not locate the specific equipment indicated in the care plan. Another staff member confirmed that the resident should have had that specific intervention and equipment in place. Current care plan interventions for the resident indicated specific interventions relating to falls was required.

Assistant General Manager and the ADOC confirmed the resident's current care plan included specific interventions relating to falls and had been in place since her admission.

There was actual harm to the resident when staff did not follow the resident's plan of care for falls prevention.

Sources: CI Report; homes investigative notes; observations; clinical record including progress notes and written care plan and interviews with the Assistant General Manager and other staff. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control program when staff did not follow the doffing procedure by not disinfecting their Personal Protective Equipment (PPE) when exiting a droplet precaution isolation room.

A staff member was observed exiting a droplet precaution isolation room without disinfecting their PPE. The staff stated they were aware of the requirement to disinfect their PPE but forgot that day.
Another staff member was observed exiting a droplet precaution isolation room on another unit without disinfecting their PPE.

According to the posted signage from the Public Health Ontario and the Disinfecting of Goggles, Face shields and Glasses policy, the staff were required to disinfect their PPE after every use or in between residents' care using disinfectant wipes or solution.

Assistant General Manager confirmed that cleaning the PPE with the disinfecting wipes was a requirement when exiting a droplet precaution isolation room and was a requirement in the doffing procedure outlined by Public Health Ontario.

Staff not following the doffing procedure may have increased the risk of resident exposure to infectious organism.

Sources: Disinfecting of Goggles, Face shields and Glasses Policy (Policy Number: 06-22, Last reviewed 08/08/2020); Public Health Ontario’s Infection Prevention and Control Department signage; observations and interviews with the Assistant General Manager and other staff. [s. 229. (4)]

2. The licensee has failed to ensure that all staff participated in the implementation of the

Infection Prevention and Control program relating to hand hygiene for residents.

During lunch observation in the residents' dining room, three residents were portered into the dining room by staff, and one resident independently walked in by himself. Staff did not provide or offer hand hygiene to these residents immediately prior to their meal.

In another observation during snack pass on the residents home area, staff distributed snacks and beverages to five resident rooms and did not perform or offer hand hygiene to these residents prior to their snack.

A review of the home's "Hand Hygiene Policy", indicated staff were to encourage the residents in promoting hand hygiene practices and offer opportunities for resident hand hygiene around meals and snack times.

The Assistant General Manager confirmed it was the home’s expectation to encourage hand hygiene before and after meals.

Failure to comply with the Hand Hygiene Policy presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Hand Hygiene Policy (Last Reviewed: 06/24/2021); observations, interview with Assistant General manager and PSW #108. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 21st day of January, 2022

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.