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
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Original Public Report

Report Issue Date: April 17, 2023

Inspection Number: 2023-1339-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Tansley Woods, Burlington

Lead Inspector	**Inspector Digital Signature**
Emma Volpatti (740883)	Emma Volpatti Digitally signed by Emma Volpatti Date: 2023.05.09 11:17:37 -04'00'

Additional Inspector(s)
Klarizze Rozal (740765)
Meghan Redfearn (000765) was present during this inspection as an observer

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 13-16, 20, 22-24, 27-29, 2023

The following intake(s) were inspected:

- Intake #00001595: Critical Incident System (CIS) report #2854-000020-22 related to the prevention of abuse and neglect.
- Intake #00004027: Complaint related to responsive behaviors, administration of drugs and consent.
- Intake #00004108: CIS report #2854-000012-21 related to the prevention of abuse and neglect.
- Intake #00011836: CIS report #2854-000030-22 related to the prevention of abuse and neglect.
- Intake #00019008: CIS report #2854-000002-23 related to falls prevention and management.
- Intake #00020036: CIS report #2854-000004-23 related to the prevention of abuse and neglect and responsive behaviors.
- The following intake(s) were completed in this inspection:

Intake #00013770, CI# 2854-000037-22; Intake #00006599, CI#2854-000007-22 were all related to falls.

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

Continence Care
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) 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)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident's plan of care was reviewed and revised to identify a change in care needs.

Rationale and Summary
Long Term Care Home (LTCH) Inspector observed a resident in their room. The resident's door was closed and responsive behavior intervention was present. Upon review of the resident's care plan, there was no documentation that the resident required this intervention.

The Assistant General Manager (AGM) and the Neighbourhood Coordinator (NC) acknowledged that the intervention should be documented in the care plan.

On March 24, 2023, the resident's care plan was updated to reflect the intervention.

Sources: Observations of a resident, a resident's care plan, interview with AGM and Neighborhood Coordinator.

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Date Remedy Implemented: March 24, 2023

WRITTEN NOTIFICATION: WHEN REASSESSMENT, REVISION IS REQUIRED

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed in relation to palliative care.

Rationale and Summary
A resident was deemed palliative and upon review of their plan of care, it did not indicate any palliative goals or interventions. A Registered Practical Nurse (RPN) acknowledged that the plan of care should have been revised when the resident became palliative.

Failure to ensure a resident's plan of care was reviewed and revised when the resident required palliative care interventions, posed a risk of improper treatment and care.

Sources: A resident's clinical record, interview with an RPN, home's policy titled Palliative/End of Life Care last revised February 25, 2023

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WRITTEN NOTIFICATION: DOCUMENTATION

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

A) The licensee has failed to ensure that a resident's outcomes of the care set out in their plan of care were documented.

Rationale and Summary
Investigation notes of an incident indicated that a resident had responsive behaviors and refused care. An RPN attempted to administer medication but the resident refused.

The resident's clinical record on that date indicated that medication was not documented as refused by the resident.

Sources: CIS report # 2852-000020-22, interview with an RPN, a resident's clinical record, home's

investigation notes

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B) The licensee has failed to ensure that a resident's outcomes of the care set out in their plan of care were documented.

Rationale and Summary
A CIS report was submitted to the Director for a fall which resulted in a change in status to a resident.

The LTCH's investigation notes indicated that the resident was found lying on the floor and had experienced a change in status. Prior to this occurring, a Personal Support Worker (PSW) had offered to provide care to the resident after their evening snack, but the resident had refused.
The resident's clinical record indicated that they had received assistance with care that evening by a PSW.
There was minimal risk to both residents when staff did not document the resident's outcomes of care set out in their plan of care.

Sources: CIS report # 2854-000002-23, Interview with a PSW, a resident's clinical record, investigation notes

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WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that an incident of alleged physical abuse was immediately reported to the Director.

Rationale and Summary
A CIS report was submitted to the Director on an identified date regarding an incident of alleged physical abuse by one resident to another.
A resident pushed another resident which resulted in a resident falling and hitting their head. The resident sustained injuries to their head and body.
The incident occurred after business hours, and the after-hours line was not called until the following day.

Sources: Interview with the DONC, CIS report #2854-000004-23, resident clinical records.

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WRITTEN NOTIFICATION: PROTECTION FROM CERTAIN RESTRAINING

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 5.

The licensee has failed to ensure that a resident was not restrained by a barrier from leaving their room.

Rationale and Summary
A resident was on isolation precautions for a suspected infection. An agency staff was instructed to ensure the resident stayed in their room because they were on isolation.
The resident exhibited responsive behaviors and would not allow staff to provide their care. The agency staff held the resident's door shut for 1-2 minutes while waiting for the RPN.

The AGM acknowledged that during their investigation, the agency staff held the door shut for 1-2 minutes.

Failing to ensure that no resident of the home was restrained from leaving their room led to increased risk of injury and harm to the resident. At the time of the inspection, interventions were in place to minimize the risk of this occurring again.

Sources: LTCH's investigation notes, CIS report # 2854-000020-22, Interview with AGM, interview with a police constable.

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WRITTEN NOTIFICATION: CONTINENCE CARE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (1) 1.

The licensee failed to ensure the continence care program provided treatments and interventions to promote continence for a resident.

Specifically, staff failed to comply with the home's Catheter Care Policy, revised February 2023, that a catheter irrigation would be done by a registered team member with a physician's order.

Rationale and Summary
A CIS was submitted to the Director regarding a resident not receiving a catheter irrigation when requested.

An RPN did not irrigate a resident's catheter as they had no irrigation order in place. An order for a catheter irrigation was initiated after. Progress notes indicated that the resident was receiving catheter irrigations with no physician orders prior to the order being initiated.

The resident was at risk for urinary retention complications when a catheter irrigation was not ordered and provided as needed.

Sources: CIS #2854-000020-22, the resident's progress notes, Medical Administration Records (MAR), Treatment Administration Records (TAR), Catheter Care Policy,04-24, and interviews with an RPN and the DONC.

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WRITTEN NOTIFICATION: ADDITIONAL TRAINING – DIRECT CARE STAFF

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.

The licensee failed to ensure that all staff who provided direct care to residents received training on falls prevention and management in 2022.

Rationale and Summary
The home's training records for direct care staff on falls prevention and management indicated that the percentage of completion for 2022 was 82%.

By failing to ensure that all staff received training led to a potential risk of staff being unfamiliar with the home's fall prevention and management program.

Sources: Interview with AGM, home's training records for 2022.

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WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

Rationale and Summary
A CIS report was submitted to the Director which reported an incident of physical abuse by one resident to another.

A resident was trying to enter another resident's room. The resident was standing at their doorway and pushed the other resident to prevent them from entering the room. The resident fell as a result and hit their head, sustaining injuries to their head and body.

Failing to protect a resident from physical abuse by another resident posed a significant risk on the resident when they sustained a head injury.

Sources: CIS report # 2854-000004-23, Interview with DONC and other staff, resident's clinical records, LTCH's investigation notes.

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