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 5, 2023
Inspection Number: 2023-1339-0004
Inspection Type: Proactive Compliance Inspection
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Tansley Woods, Burlington

Lead Inspector Dusty Stevenson (740739)	**Inspector Digital Signature** Dusty Stevenson Digitally signed by Dusty Stevenson Date: 2023.12.11 15:31:51 -05'00'

Additional Inspector(s)
Daria Trzos (561)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 8-10, 14-17, 20-21, 2023

The following intake(s) were inspected:

- Intake: #00098628 - Proactive Compliance Inspection

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

Medication Management

Food, Nutrition and Hydration
Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to respond

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
Duty to respond
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee failed to provide a response to the Residents' Council in writing within 10 days of receiving advice relating to the operation of the home.

Rationale and summary

According to a record review of the Residents' Council minutes, a meeting took place on August 31, 2023 and the council had environmental and dietary concerns, relating to the operation of the home. These concerns were received by the Interim Assistant General Manager (AGM) on September 2, 2023. The Interim AGM did not provide a response to the minutes until September 21, 2023.

On November 20, 2023, the Interim AGM indicated that the response time for the minutes received on September 2, 2023 exceeded the 10 days for required responses.

Sources: Residents' Council minutes and response letters (August 31, 2023 meeting, and response letter September 21, 2023); interview with Interim AGM [740739]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee did not implement an intervention for a resident to manage their nutritional risk

Rationale and summary

A resident's plan of care indicated they were to receive a labelled nutritional intervention daily. Inspector #740739 observed snack service on a specific day, and the resident did not receive their specific nutritional intervention.

Following snack service that day, the inspector asked a staff member if the resident received a special labelled nutritional intervention. The staff stated the resident did not receive this.

Inspector #740739 interviewed dietitian #118 who indicated that the resident was to receive the nutrition intervention daily. The dietitian checked the meal service software and indicated to the inspector that the nutrition intervention was not entered into the software therefore a label would not have been generated for the item.

Failing to provide the resident their nutritional intervention may have increased their nutritional risk.

Sources: resident's clinical records; interviews with staff; observations [740739]

WRITTEN NOTIFICATION: Menu planning

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (c)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,

(c) is approved for nutritional adequacy by a registered dietitian who is a member of the staff of the home, and who must take into consideration,
(i) subsection (1),
(ii) the residents' preferences, and
(iii) current Dietary Reference Intakes (DRIs) relevant to the resident population. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that, prior to being in effect, the 2023/2024 fall/winter menu cycle was approved by the registered dietitian.

Rationale and summary

On November 9, 2023 inspector #740739 requested the 2023/2024 Fall/Winter Menu Evaluation from dietitian #109. Dietitian #109 indicated that the menu evaluation could not be provided as it was not yet completed.

The home's Food Services Manager indicated the 2023/2024 Fall/Winter menu was launched in the home on October 23, 2023 and was aware that the menu was to be approved by the a registered dietitian in the home prior to implementing the menu.

On November 16, 2023 the menu evaluation was provided to the inspector and was indicated as being completed on November 9, 2023.

As a result, the menu was implemented in the home prior to being approved for nutritional adequacy to reflect the nutritional needs of the residents.

Sources: record review of menu evaluation tool, record review of policy Menu Review & Approval, interviews with Food Service Manager and dietitian #109.

[740739]

WRITTEN NOTIFICATION: Food production

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

The licensee failed to communicate to residents and staff that a menu substitution was made on a day in November, 2023 at afternoon snack service.

Rationale and summary

Inspector #740739 observed afternoon snack service on a day in November, 2023. The menu posted on the screen indicated that residents were to receive a different item than what was served. The inspector asked two staff members what the menu indicated was for snack and they both stated they were not aware what the menu indicated that day.

Inspector spoke with the Food Service Manager and asked if a menu substitution was made, and they indicated they were off that day and the menu item was not available. The Food Service Manager went on to indicate that the designated staff who was to update the menu screens while they were off did not do it and as a result staff and residents were not aware of the menu change.

Sources: observations, interviews with staff; record review of menu cycle (week 2). [740739]

WRITTEN NOTIFICATION: Dining and snack service

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee failed to follow their process to ensure staff are aware of resident's diets during snack service.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the nutritional care and hydration program must be complied with.

Specifically, staff did not comply with the home's Nourishment Policy, which was captured in the home's Nutritional Care program.

Rationale and summary

Inspector #740739 observed afternoon snack service on a day in November 2023. Following snack service inspector asked a staff member their process to ensure they provided the correct diet order to residents and the staff member indicated that they would check the tablet. Inspector asked the staff if they referred to the tablet during the snack service that day and they indicated they did not bring the tablet. When asked to demonstrate how to view resident meal notes in the tablet, the staff member was not aware of where to find the information on the tablet.

The home's nourishment policy was reviewed and stated "The Food Service Manager will maintain a Snack Delivery Worksheet from MealSuite for each neighbourhood snack cart. This report will include names of residents, neighbourhood and room numbers, diet orders and individual requirements." The policy goes on to state "The nursing team members will serve snacks in accordance to the information provided on the Snack Delivery Worksheet and document all food and fluid intake in the clinical software".

Food Services Manager indicated that snack carts were not equipped with Snack Delivery Worksheets as stated in the policy.

As a result, there was risk that residents may receive food or fluids that were not appropriate or safe for their assessed diet order by not following the Snack Delivery Worksheet.

Sources: observations; interviews with staff; record review of Nourishment Policy [last reviewed on 03/09/2023].
[740739]

WRITTEN NOTIFICATION: Dining and snack service

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and

independently as possible.

Staff failed to provide a resident with an assistive device to support independent feeding.

Rationale and summary

A resident's clinical records indicated they required an assistive device at lunch and dinner to support their independence.

The resident was observed at lunch in the dining room by Inspector #740739. The resident was observed to not have received their assistive device during the observation. Two staff members who were present were asked if the resident was provided their assistive device and both confirmed it was not provided.

The inspector interviewed the resident's dietitian who indicated that the resident required the assistive device to support their independence.

As a result of not providing the assistive device, the resident was not supported to promote their independence as planned.

Sources: resident's clinical records; interviews with staff; observations [740739]

WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service

s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that two residents who required assistance with eating or drinking were served a meal until someone was available to provide the assistance required by these residents.

Rationale and Summary:

During lunch meal service, Inspector #561 observed a meal placed in front of two residents while staff were not available to assist with feeding. The meal was sitting in front of the residents for approximately 10 minutes. Both residents required total assistance with feeding. The PSW staff stated that they did not have enough staff to feed the residents at that time.

Failing to serve a meal until staff member was available to provide assistance with feeding may have impacted the quality of life related to meal service.

Sources: Observation of lunch meal service; interviews with PSW staff and the Interim Assistant General Manager.
[561]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program

s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to comply with the standard or protocol issued by the Director with respect to infection prevention and control.

A) The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, section 9.1(d) indicates that as part of the routine precautions the licensee must ensure that the Routine Practices and Additional Precautions are followed related to the proper use of personal protective equipment (PPE), including appropriate selection, application, removal, and disposal.

Rationale and Summary

On a day in November 2023, personal support workers (PSWs) were observed exiting a resident's room after provision of care. The resident was on droplet precautions. One of the PSW's was not wearing the appropriate personal protective equipment (PPE) required when entering a room with a resident on droplet precautions.

Failing to follow the proper use of PPE while providing care to a resident on droplet precautions, increased the risk of spreading the infection.

Sources: Observations; review of resident's progress notes, and review of the home's Managing a Respiratory Outbreak policy; interview with PSW staff and the IPAC lead.

B) The IPAC Standard for Long-Term Care Homes dated April 2022, section 9.1(e)

indicates that at minimum additional precautions shall include point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary

On a day in November 2023, Inspector #561 observed PPE present in front of the door to a resident's room. There was no signage posted by the door to indicate what additional precautions the resident was on. A registered staff confirmed the resident was on droplet precautions and the signage should have been posted.

Failing to place appropriate signage for enhanced IPAC control measures may have increased the risk of spreading infection.

Sources: Observations; review of resident's progress notes; interview with staff and the IPAC Lead.
[561]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee has failed to ensure that the controlled substances were stored in a separate, double-locked stationary cupboard in the locked area.

Rationale and Summary

Inspector #561 observed the medication room on Appleby home area with the ADOC. The wooden box that contained controlled substances awaiting destruction was not double locked in the medication room. Inspector was also able to put their hand through the round slot and touch the medications inside.

Failing to ensure that the narcotics were stored, in a double-locked stationary cupboard in the locked area increased the risk of unsafe storage of drugs.

Sources: Observations; review of the pharmacy MediSystem manual (August 2023); interview with ADOC and the Interim Assistant GM.
[561]

WRITTEN NOTIFICATION: Retraining

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 260 (1)
Retraining
s. 260 (1) The intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

The licensee has failed to ensure that the staff in the home received re-training on the home's policy to promote zero tolerance of abuse and neglect of residents in 2022.

Rationale and Summary
A review of training records for 2022, indicated that 27.34 Per cent (%) of staff in the

home completed their annual training on Preventing, Recognizing and Reporting Abuse and Neglect that year. This was confirmed by the Interim Assistant General Manager.

Sources: Review of the training records; interview with Interim Assistant General Manager.
[561]

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care.

The licensee failed to ensure that all direct care staff received annual training in all areas required under subsection 82 (7) of the Act.

2) Specifically in skin and wound care

Rationale and summary

A review of training records for 2022 indicated that 26.80% of direct care staff completed their annual skin and wound care training that year.

The Assistant General Manager confirmed this and indicated that not all direct care

staff completed their training in 2022.

As a result, there was risk that residents may not receive the most up-to-date and relevant care related to skin and wound care.

Sources: record review of 2022 training records; interview with Assistant General Manager
[740739]

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain.

The licensee failed to ensure that all direct care staff received annual training in all areas required under subsection 82 (7) of the Act.

4) Pain management, including pain recognition of specific and non-specific signs of pain.

Rationale and summary

A review of training records for 2022 indicated that 24.24% of direct care staff

completed their annual pain management training that year.

The Assistant General Manager confirmed this and indicated that not all direct care staff completed their training in 2022.

As a result, there was risk that residents may not receive the most up-to-date and relevant care related to pain management and recognition.

Sources: record review of 2022 training records; interview with Assistant General Manager
[740739]