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: August 9, 2024	
Inspection Number: 2024-1339-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Tansley Woods, Burlington	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 22-26, 29-31 and August 1, 2024.

The following intake(s) were inspected:

- Intake: #00099498- Critical Incident (CI) #2854-000030-23 - Improper/Incompetent treatment of Resident by Staff for requirements relating to restraining by a physical device.
- Intake: #00103530 - 2854-000034-23- Fall of resident resulting in fracture.
- Intake: #00106840 - 2854-000002-24 - Neglect to Resident by Staff regarding skin and wound care
- Intake: #00114623 -Patient Ombudsman - Complainant with concerns regarding resident. Responsive behaviours.

- Intake: #00115487 - CI #2854-000017-24 - ARI - COVID - Outbreak declared 06MAY24 - Finalized 14MAY24 - Oaklands.
- Intake: #00117427 - CI #2854-000020-24 - ARI - COVID - Outbreak declared 29MAY24 - Finalized 10JUN24 - Brant.

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

Continence Care
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee failed to ensure the implementation of care plan intervention for the resident as per their plan of care.
Specifically, the licensee failed to ensure that the call bell was provided to the resident as per their plan of care.

Rationale and Summary
According to the Fixing Long-Term Care Act, 2021, s. 6 (7), the act requires the licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During an observation on an identified date, the resident was observed sitting in their wheelchair in their room without access to their call bell. Personal Support Worker (PSW) confirmed that the call bell was not within the reach of the resident during the observation and that the call bell should be within the reach of the resident as per the resident's plan of care.

The resident's plan of care stated that the call bell should be within the reach of the resident when the resident is in their room to prevent fall incidents. Registered Practical Nurse (RPN) acknowledged that if the call bell is not provided to the resident, it can increase the resident's risk of falls and limit the resident's ability to call the direct care staff for their care needs.

By not providing the call bell to the resident when they were in their room, the resident's risk of falls may not have been properly mitigated and the resident's ability to call the direct care staff may have been compromised.

Sources: Observation conducted on an identified date, record review of resident's clinical records, audio recorded interviews with PSW and RPN.

WRITTEN NOTIFICATION: Policy to minimize restraining of residents, etc.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 33 (1) (b)
Policy to minimize restraining of residents, etc.
s. 33 (1) Every licensee of a long-term care home,
(b) shall ensure that the policy is complied with.

The licensee failed to ensure the direct care staff's compliance with the policy to minimize resident restraints.

Rationale and Summary:
On an identified date, the Registered Nurse (RN) reported that the resident was found restrained in the resident's room. A Personal Support Worker (PSW) acknowledged that they restrained the resident without any order during their shift. Incident Investigation notes identified that the resident was restrained by the PSW working the night shift on the identified date.

The Assistant General Manager (AGM) confirmed that the PSW restrained the resident during their night shift on an identified date, and acknowledged that there were no orders or interventions for restraints in the resident's plan of care at the time of the incident.

There was a risk of potential physical harm to the resident due to the application of restraint by the PSW as it was not included in the resident's plan of care.

Sources: Incident investigation notes, CIS #2854-000030-23, MLTC After-hours Infoline report 18721-AH, resident's clinical records, interviews with PSW staff and AGM.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that the resident, who was exhibiting altered skin integrity, was reassessed at least weekly by an authorized person.

Rationale and Summary
On an identified date, the resident was admitted to the home with a pressure wound rated as Stage 1. After few months, the wound had deteriorated to Stage 4.

On an identified date, another pressure wound was identified on the resident and rated as a "Deep Tissue Injury". After few months, the wound had deteriorated to Stage 3.

During the time period of five months, one skin and wound evaluation for the resident's pressure wound was not completed.

During the time period of five months, 11 skin and wound evaluations for the resident's pressure wound were completed more than seven days apart.

Registered staff and DNC both acknowledged a skin and wound evaluation for the resident wound was not completed and that several skin and wound evaluations for the resident's pressure wound were completed more than seven days apart.

Failure to consistently complete a skin and wound assessment placed the resident at risk for continued deterioration of skin integrity as there could have been delayed detection, treatment and care for the resident's wounds.

Sources: Resident's Wound Evaluations and interviews with RPN and DNC.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee has failed to ensure that the resident who was dependent on staff for repositioning was repositioned every two hours as required.

Rationale and Summary
On an identified date, the resident was admitted to the home with a Stage 1 pressure wound. The resident's Care Plan states the resident was to be repositioned every two hours while in bed.

A review of Skin and Wound Evaluations for a period of five months reflected that the resident's pressure wound deteriorated from Stage 1 to Stage 4.

A review of clinical records specific to the task of repositioning the resident every two hours demonstrated numerous instances when the resident was not repositioned every two hours. This was acknowledged by DNC and PSW who described that when documenting in POC that a task has been completed, staff are trained to adjust the time from the auto-populated current time to the actual time the task was completed.

Registered staff reviewed the POC Documentation Survey Report and confirmed that what was documented in the Survey report reflected that the resident was not repositioned every two hours on multiple occasions during the month.

Failure to ensure that the resident was turned and repositioned every two hours potentially compromised wound healing.

Sources: Resident's Care Plan, resident's Wound Evaluations; and interviews with PSW, RPN and DNC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (10)
Infection prevention and control program
s. 102 (10) The licensee shall ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 246/22, s. 102 (10).

The licensee has failed to ensure that the information gathered under subsection (9)

is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Rationale and Summary
The home's current Infection Prevention and Control (IPAC) lead did review and analyze the gathered information on a quarterly basis to detect trends, for the purpose of reducing the incidence of infection and outbreaks. During the audio recorded interview with IPAC lead, they acknowledged that they were new in their role and they followed what was happening before for the program. They have not reviewed and analyzed the information gathered monthly to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Not reviewing and analyzing the gathered data to detect trends for the purpose of reducing the incidence of infection and outbreaks puts the residents at risk for managing infections and keeping the residents safe.

Sources: Interview with IPAC lead and Trend Analysis Reports of the home.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant

change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee failed to ensure that the Director was informed of the resident's fall with injury that required hospitalization within three business days after occurrence of the incident.

Rationale and Summary
On an identified date, the resident was injured as result of fall. The home contacted the hospital and was informed that the resident had surgical intervention. CIS #2854-000034-23 was submitted, exceeding the three business days from the date of the incident. The DNC (Director of Nursing) acknowledged that the CIS was not submitted within three business days after the incident, when they were unable to determine whether the injury resulted in a significant change.

Sources: Clinical records of the resident, Progress notes, Interview with DNC and CIS # 2854-000034-23.

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.
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:

1. Falls prevention and management.

The licensee has failed to ensure that all staff who provided direct care to residents received training on Falls Prevention and Management in 2023.

Rationale and Summary
The home's training records for 2023 identified that not all direct care staff completed the mandatory training as required related to Falls Prevention and Management.

There was a risk that not all direct care staff were familiar with the home's Falls Prevention and Management program when they failed to complete the annual training as required.

Sources: Review of Mandatory completion reports and interview with the AGM (Assistant General Manager) and Quality Specialist.

COMPLIANCE ORDER CO #001 Requirements on licensee before discharging a resident

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (c)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; and

The inspector is ordering the licensee to comply with a Compliance Order:
Specifically, the licensee shall:

1. Ensure the management in the home, and any other persons responsible for discharging a resident, reviews the following legislation:
    1. Ontario Regulations, 246/22, s. 156 related to "Restriction on discharge."
    2. Ontario Regulations, 246/22, s. 157 related to "When licensee may discharge."
    3. Ontario Regulations, 246/22, s. 161 related to "Requirements on licensee before discharging a resident."
2. Document and maintain a record of the review of the legislation outlined in part 1. including the date and time the review occurred, the names, title, and signature of who participated in the review, and the name of the person who conducted the review.
3. Upon review of the regulations, the Licensee must conduct a thorough review of their Discharge policy, to ensure that it aligns with all regulatory requirements outlined in O. Reg. 246/22 as it pertains to discharges.

Grounds

The licensee failed to ensure that resident the resident was given the opportunity to participate in their discharge planning and that their wishes were taken into consideration before being discharged from the home.

Rationale and Summary

The Resident's clinical records showed that they consistently exhibited aggression towards others for the duration of their stay in the home. The resident's family member was and remains their Power of Attorney (POA). The records reflected the home's medical team had recommended medical interventions to manage the resident's expressions though the resident's POA consistently refused and requested the use of alternative strategies. Records reflected the home provided the resident with supports and external services and made adjustments to their living arrangement.

The resident was ultimately discharged from the home on an identified date. The resident did not return to the home after being sent to hospital.

On an identified date, the resident was sent to the hospital by the home's Medical Doctor (MD). In a note written by the MD, the MD stated resident was observed striking others and was aggressive with responding police. The MD wrote the POA refused the medical intervention despite the risk the resident posed to others, and that the MD felt the resident could not be safely managed in the home.

Video footage of the incident provided by the home's DNC (Director of Nursing Care) was reviewed. The footage reflected the resident appearing to attempt to hit others though the resident did not appear to make physical contact with another person. The home's DNC stated no Critical Incident (CI) report was submitted to the Ministry regarding this incident as there were no injuries.

Through a review of documentation of email communication and an interview with the hospital's Discharge Planner (DP), information was gathered that indicated the home was informed by email and video call that the resident was medically stable to return to the home and cleared for discharge, their expressions were well managed, and there was no need for medical intervention.

The hospital DP stated they received a phone call from the home's DNC and Assistant General Manager (AGM) on an identified date that indicated they would

not allow the resident back to the home if the resident does not agree with medical interventions.

On an identified date, the AGM sent the hospital DP an email that stated the medication prescribed to the resident by the hospital was not the "preferred medication for stabilizing" the resident and that the length of the stay in hospital was insufficient to assess stability. The email stated the home could not readmit the resident without the resident being "under appropriate medical management and observed for an adequate duration".

On an identified date, the home sent the resident's POA a letter titled "Notice of Discharge" which in part stated although the hospital deemed the resident stable, the home's MD and a consulting physician did not believe any meaningful change took place and that the resident continued to be a risk to others.

Email records reflected the resident's POA contacted the home several times expressing dissatisfaction after the resident's hospital transfer and after receiving the Notice of Discharge. The email records reflected the POA contested the resident's discharge from the home and cited negative impacts on the resident.

The AGM stated the home was informed by hospital staff that the resident's POA had made comments that the POA did not want the resident to return to the home. The AGM stated after they learned about the comments the POA reportedly made to hospital staff, no meeting was offered to the POA to discuss discharge planning. The AGM acknowledged the POA did not make statements regarding not wanting the resident to return to the home directly to anyone from the home.

The resident's POA described significant negative impacts as a result of the resident's discharge. The POA expressed concern that information provided to other LTCHs by the home was inaccurate and would impede the resident's ability to be accepted into another home.

The POA stated they were not offered any discharge meeting by the homed despite being open to discussing the resident's return to the home and progress in hospital without the use of medical intervention. The POA expressed disappointment that no one from the home came to see the resident in hospital to clinically observe their progress and that many of the POA's emails and voicemails went unanswered by the home.

When the home failed to provide the resident's POA with an opportunity to participate in the discharge planning and ensure that their wishes were taken into consideration, the resident was negatively impacted as they were denied the right to return to the home and left with no permanent accommodation despite being deemed stable and cleared for hospital discharge 20 days after the resident's transfer to hospital. The negative impacts extended to the resident's POA who described significant emotional and financial impacts as a result of the resident's discharge.

Sources: Resident's clinical records; interviews with the AGM, DNC, hospital Discharge Planner, and POA; hospital documentation; and records of email communication.

This order must be complied with by September 16, 2024

COMPLIANCE ORDER CO #002 Additional training — direct care staff

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (7) 1.
Training
s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the

areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that all the direct care staff complete their annual training on the prevention of resident abuse and neglect.

Specifically, the licensee must:

1. Retrain all the direct care staff on the home's abuse recognition and prevention program.
2. Maintain a record of the education content, who provided the education, when it was provided, and a sign-off sheet showing that all the direct care staff completed the required education.

Grounds

The licensee failed to ensure that all direct care staff received annual training in all areas required under subsection 82 (7) 1 of the Act.

Specifically:

1. Abuse recognition and prevention.

Rationale and summary

A review of staff training records for 2023 indicated that not all the home's direct care staff completed their annual prevention of resident abuse and neglect training that year.

The home's Quality Specialist and Assistant General Manager confirmed this and indicated that not all direct care staff completed their training for the year 2023.

By not completing mandatory training on Preventing, Recognizing, and Reporting Abuse and Neglect in Long Term Care Home, the direct care staff may not have properly mitigated the risk of resident abuse and neglect in the Long-Term Care Home.

Sources: Record review of staff training records 2023, interviews with Quality Specialist and Assistant General Manager.

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #003 Additional training — direct care staff

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall ensure that all the direct care staff complete the mandatory annual training related skin and wound care.

Specifically, the licensee must:

1. Train all the direct care staff who were not trained in 2023 related to the home's skin and wound care program.
2. Maintain a record of the training including the date of the training, name of staff trained and their role, and the platform used to conduct the training. A record of the training is to be kept and made available to the Inspector upon request.
3. This training is in addition to any training requirement(s) for 2024.

Grounds

Rationale and Summary

The home's training completion record for 2023 indicated that 33% of RNs and 62% of RPNs and PSWs completed the mandatory training related to Skin and Wound Care.

By not ensuring all direct care staff were familiar with the home's Skin and Wound Direct Care training, the health and well-being of the residents were put at risk.

Sources: Completion rate report and interview with AGM and Quality Specialist.

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #004 Additional training — direct care staff

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 261 (1) 3.

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:

3. Continence care and bowel management.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall ensure that all the direct care staff complete their annual training on the home's continence care and bowel management program.

Specifically, the licensee must:

1. Retrain all the direct care staff on the home's continence care and bowel management program.
2. Maintain a record of the education content, who provided the education, when it was provided, and a sign-off sheet showing that all the direct care staff completed the required education.

Grounds

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

3) Specifically in Continence Care and Bowel Management.

Rationale and summary

A review of training records for the year 2023 indicated that all the direct care staff had not completed their annual Continence Care and Bowel Management training that year.

The Associate Director of Nursing (ADNC) confirmed that all the direct care staff had not completed their training for the year 2023.

As a result, there was a risk that residents may not receive the most up-to-date and relevant care related to Continence Care and Bowel Management.

Sources: Record review of 2023 annual staff training records for Continence Care and Bowel Management Program and an audio-recorded interview with ADNC.

This order must be complied with by September 30, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.