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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: October 18, 2024
Original Report Issue Date: October 16, 2024
Inspection Number: 2024-1339-0002 (A1)
Inspection Type: Critical Incident Follow up
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Tansley Woods, Burlington

AMENDED INSPECTION SUMMARY

This report has been amended to reflect the order #001 from Inspection #2024-1339-0001 related to O. Reg. 246/22, s. 161 (2) (c) was complied.

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This report has been amended to reflect the order #001 from Inspection #2024-1339-0001 related to O. Reg. 246/22, s. 161 (2) (c) was complied.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 24, 26-27, October 1-2, 2024.

The following intake(s) were inspected:

- Intake: #00112460 - Prevention of abuse and neglect.
- Intake: #00120110 - Falls prevention and management.
- Intake: #00125416 - Admission, Absences and Discharge.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1339-0001 related to O. Reg. 246/22, s. 161 (2) (c) inspected by Patrishya Allis (000762)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management
Admission, Absences and Discharge

AMENDED 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 (1) (a)

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,

(a) the planned care for the resident;

The licensee failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident, specific to the use of an injury prevention device.

Rationale and Summary

The falls incident report completed on a date in 2024 indicated a protective device was a new falls prevention strategy that was implemented to reduce the risk of another fall or injury.

A resident's plan of care documentation did not have the protective device indicated as an intervention. This was acknowledged by a member of the management team.

Failing to document the use of a protective device in the resident's plan of care led to potential risk of missed falls interventions being implemented.

Sources: Resident clinical records, resident observations.

[000762]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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 licensee failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident, specific to transferring.

Rationale and Summary

Review of a resident's plan of care indicated resident was to self transfer in a specified way.

Review of Point of Care (POC) documentation indicated an equipment was to be used for transfer.

A registered staff acknowledged the plan of care and POC documentation were not consistent and did not complement each other.

Failure to provide clear direction to staff regarding transfer status for the resident increased the risk of an improper transfer to occur.

Sources: Interviews with staff, resident clinical records.
[000762]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care for a resident was documented, specific to compliance with the toileting program.

Rationale and Summary:

A resident's specific care needs focus in the plan of care indicated "team member(s) to assist/encourage resident to use the washroom upon awakening, before attending the dining room, after meals, and before bedtime, and as needed".

A staff member who worked with the resident during the evening shift on a date in 2024, reported they were aware of the resident's toileting requirements and they toileted the resident at the care planned time.

Review of the follow-up documentation report indicated the resident was not toileted at the care planned time. This was acknowledged by a member of the management team.

Failing to document the provision of care set out in the plan of care led to inaccurate information of the care that was provided to the resident.

Sources: interviews with staff, resident clinical records.

[000762]

WRITTEN NOTIFICATION: Duty to Protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from abuse.

Section 2 of the Ontario Regulation (O. Reg 246/22) defines "physical abuse" as the use of physical force by anyone other than a resident that causes physical injury.

Rationale and Summary

On a date in 2024, a concern was received about a visitor to resident abuse.

A skin assessment was completed with an injury to the resident. Two members of management confirmed the injury was a result of the interaction from the visitor and the resident.

Failure to protect the resident from abuse led to actual harm.

Sources: Video footage, resident's clinical records, and interviews with staff. [000763]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to ensure that every alleged or suspected abuse of a resident by anyone is immediately investigated.

Rationale and Summary
An allegation of abuse with injury was reported to the home in 2024.
The LTCH's Investigation Process for Suspected Abuse of a Resident indicated that a member of the leadership team will conduct a full investigation into the incident of abuse, and will include, documenting the event, including date, time and person, individually interviewing witnesses, which could include other team members, residents or visitors.

A member of the management team confirmed they provided care to resident and the injury but they did not complete an investigation for the suspected abuse.

Failure to complete an investigation of abuse could have led to ongoing risk of harm to the resident.

Sources: Investigation Process for Suspected Abuse, Investigation notes, staff interview.
[000763]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report the suspicion of abuse of a resident by anyone and the information upon which it is based to the Director.

Rationale and Summary
The Ministry of Long-Term Care received a Critical Incident (CI) on a date in 2024 relating to abuse. The CI was received two days after the incident occurred. A member of the management team acknowledged that a CI should have been submitted to the Director immediately on the date of the incident.

Sources: Critical Incident Report, and interview with staff.
[000763]

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to provide for strategies to reduce or mitigate falls, including implementation of a specified functioning device.

Rationale and Summary:
On a date in 2024, a resident fell, was found on their bedroom floor with injuries.

Resident was at risk for falls and had a specified device implemented in their care plan as an intervention to reduce their risk for falls.

A staff member confirmed they were not alerted by the device and it was not in place on the date of the fall.

A registered staff could not recall if the device was present and reported it would have been beneficial to have it in place to reduce the risk of a fall.

Failure to implement a device increased the risk of a fall as staff were not alerted that the resident arose from bed.

Sources: interviews with staff, resident clinical records, Critical Incident Report. [000762]