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

Public Report

Report Issue Date: December 20, 2024

Inspection Number: 2024-1339-0003

Inspection Type:
Critical Incident
Follow up

Licensee: Schlegel Villages Inc.

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 27-29, and December 2- 6, 2024.

The following intake(s) were inspected:

- Intake: #00125413 - Follow-up - Fixing Long-Term Care Act (FLTCA), 2021 - s. 82 (7) 1. Compliance Due Date (CDD) September 30, 2024.
- Intake: #00125414 - Follow-up - Ontario Regulation (O. Reg.) 246/22 - s. 261 (1) 2. CDD September 30, 2024.
- Intake: #00125415 - Follow-up - O. Reg. 246/22 - s. 261 (1) 3. CDD September 30, 2024.
- Intake: #00125104 - Critical Incident (CI) 2854-000026-24 related to abuse
- Intake: #00125835 - CI #2854-000028-24 - related to abuse
- Intake: #00126449 - CI #2854-000031-24 - related to abuse
- Intake: #00127396 - CI #2854-000032-24 - related to medications, missing/unaccounted controlled substance
- Intake: #00128155 - CI #2854-000034-24 - related to personal support services
- Intake: #00128227 - CI #2854-000033-24 - related to falls
- Intake: #00129189 - CI #2854-000035-24 - related to infection prevention and control (IPAC) infectious disease outbreak

- Intake: #00129940 - CI #2854-000036-24 - related to safe and secure home, falls

The following intake was completed:

- Intake #00131833 - CI #2854-000038-24 - related to abuse

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2024-1339-0001 related to FLTCA, 2021, s. 82 (7) 1.
Order #003 from Inspection #2024-1339-0001 related to O. Reg. 246/22, s. 261 (1) 2.
Order #004 from Inspection #2024-1339-0001 related to O. Reg. 246/22, s. 261 (1) 3.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and 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)
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 has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

A resident was observed without a planned care intervention in place. Staff confirmed the intervention was to be in place.

Prior to the conclusion of the inspection, the care set out in the resident's plan of care was provided.

Sources: Observation, plan of care, interview with staff.

Date Remedy Implemented: An identified date in November 2024.

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 has failed to ensure that a resident's written plan of care set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
A resident's electronic medication administration record (eMAR) contained direction for a specified intervention. The resident's clinical record also contained an order for a different intervention, which was not included in the resident's eMAR.

Nursing staff noted the second intervention was to be used if the first intervention was not tolerated; however, the written order for the second intervention did not specify the direction as described by the staff.

Failure to ensure the written plan of care contained clear direction increased risk that the resident would not receive treatment appropriate for their specific needs.

Sources: A resident's health records, interview with staff.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that when a resident demonstrated a change in care needs, their plan of care was reviewed and revised.

Rationale and Summary
A resident's care needs changed in relation to their psychosocial condition.

No interventions were added in their plan of care when their care needs changed.

There was risk that the resident would not receive the support they needed when their plan of care was not revised.

Sources: A resident's health records, other documentation, interviews.

WRITTEN NOTIFICATION: General requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that the reassessment of a resident was documented.

Rationale and Summary
A resident demonstrated a change in condition that required reassessment. A referral was made for the resident to be reassessed; however, there was no documentation of a reassessment.

Staff confirmed the reassessment of the resident was not documented.

Sources: A resident's health record, other documentation, interview with staff.

WRITTEN NOTIFICATION: Housekeeping

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

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that procedures were implemented for cleaning and disinfection of contact surfaces.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b), as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee is required to ensure that procedures are developed and implemented for cleaning and disinfection of contact surfaces in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practice.

Specifically, staff did not comply with procedures outlined in the home's "Cleaning Principles" policy.

The policy included direction on how to perform daily cleaning of resident rooms.

During the inspection, a daily clean of a shared resident room and washroom was observed. Staff failed to clean all required high touch surfaces and follow the home's procedures for daily cleaning of the shared room and washroom.

Not following the home's procedure for cleaning and disinfecting of contact surfaces had potential to increase risk of transmission of infection.

Sources: A home policy, an observation, interviews.

WRITTEN NOTIFICATION: Maintenance Services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

The licensee has failed to ensure that the procedures developed for a specified type of equipment used in the home that met manufacturer specifications, at a minimum were implemented.

Rationale and Summary
In accordance with manufacturers' specifications to ensure safe operation of a specified type of equipment, policies at the home required staff to use an approved checklist prior to use of the specified type of equipment. Staff were to document and initial each inspection item on the approved checklist to determine if the equipment could be safely operated.

It was reported that pre-start up inspections of the specified equipment had occurred; however, the documentation of the inspections prior to the use of the equipment was not completed over an identified period.

There was potential risk that staff could not identify the safe operation of the equipment when the home did not document the daily inspection of the device.

Sources: Home policies, an operating manual, checklists, other records, interviews.

WRITTEN NOTIFICATION: Monitored dosage system

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 134 (2)
Monitored dosage system
s. 134 (2) The monitored dosage system must promote the ease and accuracy of the administration of drugs to residents and support monitoring and drug verification activities.

The licensee has failed to ensure they promoted the ease and accuracy of the administration of drugs to residents and supported monitoring and drug verification activities by counting a specified type of drug at the beginning of every shift.

Rationale and Summary
The home's process for handling a specified medication required staff to ensure the specified medication was counted at the beginning and end of every shift.

An incident occurred in the home where registered nursing staff did not follow the home's safe medication administration policy. The staff failed to count a specified medication, document the count of the medication prior to starting their shift, and document right after administering the medication.

Failure to ensure that the home's process was followed could put a resident's health at risk.

Sources: A resident's health records, other records, interviews, a policy.

WRITTEN NOTIFICATION: Residents' drug regimes

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (b)
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(b) appropriate actions are taken in response to any medication incident involving a resident, any incidents of severe hypoglycemia and unresponsive hypoglycemia and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

The licensee has failed to ensure that appropriate actions were taken in response to a medication incident involving a resident's documentation.

Rationale and Summary
In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that the written policy that deals with accountability to never deleting, altering, or modifying anyone else's documentation was complied with.

Specifically, staff did not follow the process of the home's policy by altering other staff's documentation regarding a medication count.

It was acknowledged that a staff did not follow the home's process by altering documentation by other staff.

Sources: Progress notes, investigation notes, incident reports, interview, a policy.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee has failed to ensure that a medication incident involving a resident, was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary
The home's policy, "Administration of Medications" required registered staff to follow the College of Nurses (CNO) standard, which stated that staff should document care provided in a timely manner. The standard also stated that nurses are required to make and keep records of their professional practice and are accountable for ensuring that their documentation is accurate and meets the College's practice standards.

A registered nursing staff of the home did not document on a medication incident that happened during their shift. It was acknowledged that staff did not follow the home's safe medication administration policy.

Failure to ensure that the home's process was followed had potential to put the resident's health at risk.

Sources: A resident's health records, investigation reports, interview, a policy.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a medication incident involving a resident was reported to the registered nurse on duty during the shift when the incident occurred.

Rationale and Summary
The home's policy, "Administration of Medications" stated that nurses must report medication errors, near misses or adverse reactions in a timely manner and comply with applicable legislative requirements.

On a specified shift, a medication incident was discovered by a member of the registered nursing staff. The Registered Nurse in charge and the leadership team were not notified, as required by the home's policy.

Staff confirmed the incident should have been reported on the same shift to the

registered nurse in charge and staff did not follow the home's process in place.

Failure to ensure that the home's process was followed could put the resident's health at risk.

Sources: Progress notes, internal records, interview, an incident report, a policy.

WRITTEN NOTIFICATION: Resident records

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record was kept up to date at all times.

Rationale and Summary
The home defined a resident's written record as documentation in the resident's physical chart, Point Click Care (PCC), and Point of Care (POC).

The home's policy, "Resident Care Documentation" also indicated charting will be electronic within the current computerized software system.

A resident's written record did not contain documentation of reassessments made by a staff. Follow-ups were documented on a record that was not part of the resident's written record.

There was risk that the interdisciplinary team would not be made aware of reassessments when they were not included in the resident's written record.

Sources: A resident's written record, other documentation, a policy, interviews.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1) Provide education and training to the home's Outbreak Management Team (OMT) and interdisciplinary IPAC team of the requirement set out under Section 4.3 of the IPAC Standard for Long-Term Care (LTC) Homes, revised September 2023. Maintain a record of the education, names and signatures of staff who received the education, the date(s) the education was provided, and the name(s) of the person(s) who provided the education.

2) Following the resolution of any outbreak, ensure the OMT and the interdisciplinary IPAC team conduct a debrief session and ensure there is a record of the summary of findings that includes recommendations for improvements to outbreak management practices.

3) Provide education and training on the four moments of hand hygiene as well as personal protective equipment (PPE) use. Maintain a record of the education

provided, the name(s) of person(s) who provided the education, the date(s) the education was provided, as well as the name and signature of the staff receiving the education.

4) Perform audits twice weekly for a period of three weeks on the four moments of hand hygiene and PPE use. Maintain a record of all audits, including the staff completing the audit, dates and times audits were completed, and any corrective action taken, if necessary.

Grounds

A. The licensee has failed to implement the IPAC Standard for LTC Homes, issued by the Director related to outbreak preparedness and management.

Rationale and Summary
The IPAC Standard for LTC Homes states under Section 4.3 that the licensee shall ensure that following the resolution of the outbreak, the OMT and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak and that a summary of findings be created that makes recommendations to the licensee for improvements to outbreak management practices.

In October 2024, the home was in a coronavirus (COVID-19) outbreak in two resident neighbourhoods.

Staff confirmed following the resolution of the outbreak, no debrief session occurred by the OMT and the interdisciplinary IPAC team to assess IPAC practices that were effective and ineffective in the management of the outbreak.

Failure to summarize findings of the outbreak and provide recommendations for improvement to outbreak practices following the October 2024 COVID-19 outbreak

increased potential for continuation of ineffective IPAC practices in the home related to outbreak prevention and management.

Sources: Interview, Outbreak Analysis Debrief Template, an outbreak incident report.

B. The licensee has failed to implement the IPAC Standard for LTC Homes, issued by the Director related to routine precautions.

Rationale and Summary
The IPAC Standard for LTC Homes states under Section 9.1 Routine and Additional Precautions, that at minimum, Routine Practices, shall include hand hygiene, including, but not limited to, the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

During the inspection, a staff member did not perform hand hygiene before applying or after removing gloves when cleaning.

Failure to perform hand hygiene when indicated as part of routine precautions had potential to increase risk of transmission of infection.

Sources: Observation, interview.

This order must be complied with by January 31, 2025.

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.