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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: July 10, 2024

Inspection Number: 2024-1386-0002

Inspection Type:
Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Taunton Mills, Whitby

Lead Inspector	**Inspector Digital Signature**
Rexel Cacayurin (741749)	Rexel J Cacayurin Digitally signed by Rexel J Cacayurin Date: 2024.07.15 12:20:37 -04'00'

Additional Inspector(s)
Kornelija Delibasic (000852) was present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 24-28, 2024 and July 2- 3, 2024.

The following intake(s) were inspected:

- An intake related to resident's fall.

The following intake was completed in this inspection:

- An intake related to fall.

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

Continence Care
Skin and Wound Prevention and Management
Infection Prevention and Control
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 26

Compliance with manufacturers' instructions

s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that staff use disinfectant equipment, in the home in accordance with manufacturers' instructions.

Rationale and Summary

A disinfectant wall unit was observed in the housekeeping closet which was being used by the home to dilute and dispense the general disinfectant for cleaning and

disinfection of contact surfaces in the home.

Two Housekeepers indicated that they had never conducted testing of the diluted disinfectant solution from the wall unit. Further, the Director of Environmental Services confirmed the same.

An email was received by the Director of Environmental Services from the manufacturer's account manager, which indicated that the recommendations for testing chemical would be to have a sign off sheet inside their Environmental closet, staff with a test strip should be testing the chemical in their bucket right after the chemical is dispensed in the morning. The testing should be done daily to make sure that the staff are disinfecting at the right concentrations.

By failing to ensure that staff used all equipment, supplies, and devices in the home, in accordance with manufacturers' instructions, the licensee increased the risk for health care-associated infections.

Sources: Observation, interviews with the housekeeping staff and Director of Environmental services, email from manufacturer's account manager. [741749]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident after an unwitnessed fall.

Rationale and Summary

A Critical Incident Report was submitted to the Director related to resident's unwitnessed fall resulted in an injury.

The resident was found lying on the bathroom floor and soiled. .

RPN (Registered Practical Nurse) indicated that the resident was moaning and was in pain while on the floor in a specified position. The resident was transferred from the floor to the shower chair using a specialized lift. They observed the resident to have an injury and suspected a change in condition upon further observation. Further, RN (Registered Nurse) indicated that resident should not be in a lift as they were suspected to have an injury

The Falls lead and RN indicated that the expectation of the home was to not move the resident when suspected to have an injury or pain after an unwitnessed fall.

Failing to ensure that staff used safe transfer and positioning techniques resulted in significant injury to the resident.

Sources: CIR, home's internal investigation documents, and interview with Falls lead and RN. [741749]