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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: September 5, 2023

Inspection Number: 2023-1474-0006

Inspection Type:
Complaint
Critical Incident
Follow Up.

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village at St. Clair, Windsor

Lead Inspector	**Inspector Digital Signature**
Jennifer Bertolin (740915)	Jennifer Bertolin Digitally signed by Jennifer Bertolin Date: 2023.09.08 12:55:49 -04'00'

Additional Inspector(s)
Rhonda Kukoly (213)
Adriana Congi (000751)
Terri Daly (115)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 22- 25 and 28-29, 2023
The inspection occurred offsite on the following date(s): August 22, 28, 2023

The following intake(s) were inspected:

- Intake: #00083952 - Follow-up intake CO#001 from inspection 2023-1474-0004 - Pain Management
- Intake: #00089249 - [3046-000052-23]: Falls Prevention & Management
- Intake: #00089910 - Follow-up Order #1 from inspection #2023-1474-0005 -Falls Prevention & Management
- Intake: #00089912 - Follow-up Order #2 from inspection #2023-1474-0005 -Infection Prevention & Control
- Intake: #00089911 - Follow-up # Order #3 from inspection #2023-1474-0005-Infection Prevention & Control
- Intake: #00089913 - Follow-up Order #4 from inspection #2023-1474-0005 - Medication Management

- Intake: #00090037 - [IL-14208-LO/IL-15433-LO/IL-16259-LO]: Prevention of Abuse & Neglect; Skin & Wound Care; Food, Nutrition, & Hydration; Resident Care & Support Services, and Medication Management
- Intake: #00090115 - [IL-14241-LO/IL-14551-LO / IL-15707-LO]: Medication Management
- Intake: #00092320 - [IL-15337-LO]: Food, Nutrition, & Hydration

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order ##001 from Inspection #2023-1474-0004 related to O. Reg. 246/22, s. 261 (1) 4. inspected by Terri Daly (115)

Order #001 from Inspection #2023-1474-0005 related to FLTCA, 2021, s. 6 (7) inspected by Terri Daly (115)

Order #003 from Inspection #2023-1474-0005 related to O. Reg. 246/22, s. 102 (8) inspected by Jennifer Bertolin (740915)

Order #002 from Inspection #2023-1474-0005 related to O. Reg. 246/22, s. 102 (10) inspected by Jennifer Bertolin (740915)

Order #004 from Inspection #2023-1474-0005 related to O. Reg. 246/22, s. 140 (2) inspected by Terri Daly (115)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

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 (2)

The licensee has failed to ensure that the care set out in the plan of care is based on an assessment and on the needs and preferences of a resident in relation to their history of infections.

Rationale and Summary
A resident had a history of infections since prior to their admission to the home.

The resident's plan of care noted the resident's history however there were no specific or individualized signs or symptoms, behaviours or indicators based on the home's assessments.

During an interview with management, they indicated that this information would be found under a certain section in the care plan.

During a review of the clinical record with a staff member, they indicated that this was not noted in a resident's care plan, and that it was something that should have been identified with the resident's history and ongoing bacterial infections.

Sources: Clinical record and staff interviews.
[115]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a resident’s skin and wound dressing was changed daily as ordered.

Rationale and Summary

A complaint related to multiple care concerns, including skin and wound management, for a resident, was received by the Ministry of Long-Term Care.

A resident had an order to change the skin and wound dressing daily and as needed. The Treatment Administration Records showed the dressing was signed as completed for only 15 out of 28 days in a one month period.

A staff member said that they did not change the dressing every day. Management indicated the expectation is that dressings are changed as per orders. There was risk to the resident's altered skin integrity that could worsen when the dressing was not changed as ordered.

Sources: Health records for a resident and staff interviews**.**

[213]

WRITTEN NOTIFICATION: Unsafe transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe and proper transferring and positioning techniques when assisting a resident with a transfer.

Rationale and Summary
Review of the records showed improper transferring and positioning techniques were utilized by staff while using a mobility device to assist a resident in a transfer.

The home's safe lift and transfer policy directed staff in the proper techniques in transferring and positioning residents for a safe transfer. The staff did not use these techniques during the transfers according to records.

Management and a member of the interdisciplinary team acknowledged that the records showed unsafe transfers and positioning.

Failure to use safe transferring and positioning techniques placed the resident at risk of injury.

Sources: Records; Safe Lift and Transfer policy; interviews with management, and a member of

the interdisciplinary team, and other staff.
[000751]

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