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
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London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: April 25, 2024

Inspection Number: 2024-1474-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Schlegel Villages Inc.

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

Lead Inspector	**Inspector Digital Signature**
Terri Daly (115)	Terri Daly Digitally signed by Terri Daly Date: 2024.05.06 18:44:00 -04'00'

Additional Inspector(s)
Stacey Sullo (000750)
Peter Hannaberg (721821)
Cassandra Taylor (725)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 19, 20, 21, 22, 25, 26, 27, and 28, 2024.

The following intake(s) were inspected:

- Intake: #00105519 - CI #3046-000002-24 - Improper/Incompetent treatment.
- Intake: #00106778 - CI #3046-000007-24 - Resident to resident incident.
- Intake: #00107004 - CI #3046-000008-24 - Resident to resident incident.
- Intake: #00107731 - CI #3046-000011-24 - Resident fall with injury.
- Intake: #00108474 - CI #3046-000012-24 - Outbreak
- Intake: #00109563 - CI #3046-000017-24 - Outbreak

- Intake: #00109895 - CI #3046-000018-24 - Resident to resident incident.
- Intake: #00110127 - CI #3046-000019-24 - Resident Incident.
- Intake: #00110658 - CI #3046-000021-24 - Outbreak
- Intake: #00111066 - CI #3046-000023-24 - Resident to resident incident.
- Intake: #00111079 - Complaint concerns related to responsive behaviours.
- Intake: #00106036 - Complaint concerns related to a medication incident.

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

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and Secure Home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that the home was a safe and secure environment for its residents.

RATIONALE AND SUMMARY:
During an Infection Prevention and Control observation tour of the home and additional observations on two other days, the following areas related to an unsafe environment were identified.

Inspector observed the following:
-The stove top ovens in the country kitchens in three neighbourhoods were found to be accessible with the power switch located in the locked cupboard above the units found to be unlocked and accessible.
- The inspector found one of the country kitchen stove top ovens accessible, power switch cupboard above was not secure and the inspector was able to turn the stove top burners on resulting in the burner illuminating red and inspector unable to touch due to extreme heat.

During an interview with the General Manager (GM) they indicated that the power

switch located in the locked cupboard above the units was to be secured/locked when not in use by family or staff.

Failure to keep the power switch to the stove top ovens secure, results in a risk of harm to residents.

SOURCES: Interviews and observations.
[115]

WRITTEN NOTIFICATION: Accommodation Services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)

Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

RATIONALE AND SUMMARY:
During an Infection Prevention and Control observation tour of the home and additional observations on two other days, the following areas and furnishings were noted to be unclean.

Inspector observed the following:
-furniture in four neighbourhood resident lounges and parlours were worn and stained.

-food debris and food splatter on resident tables, chairs, staff feeding stools and wall baseboard heaters in six out of the eight dining rooms.
-dining room linen/serving carts on two neighbourhoods was splattered with food debris, food splatter, and build up of debris around wheels and base of steel frame of the carts.
-old cigarette butts on three resident neighbourhood patios.
-drawers in the spa rooms on two neighbourhoods found with debris and hair on bottom surface and corners.

A review of the home's complaint log showed two recent complaints from a family member of a resident living in one of the neighbourhoods about cleanliness. The home's complaint tracking noted that the home formulated an action plan and that the issues were resolved.

A review of the home's Family Council meeting minutes from last fall under new business, a concern was identified in a resident dining room, family noted that it felt dirty, food on the floor and tables, food from breakfast not cleaned up at lunch. The home's Environmental Services Manager (ESM) responded to the council that the deep cleaning of dining rooms is completed quarterly.

A review of the home's Resident Council meeting minutes from early this year indicated that residents in attendance had a concern related to cigarette butts on one of the patio neighbourhoods. This concern was forwarded to the Neighbourhood Coordinator who responded that they would follow up with the team.

A review of the home's policy and procedure titled Environmental Services – Objectives for the Department indicated the following:
It is the policy of Schlegel Villages to contribute to the quality of life of the residents

by ensuring that their physical environment is clean, safe, well maintained, and comfortable.

It is the policy of Schlegel Villages to contribute to the quality of life of the residents by ensuring that their physical environment is clean, safe, well maintained, and comfortable.

An interview with two Housekeeping Aides both indicated that dining rooms are deep cleaned every three months and that this task includes cleaning and removing food debris and food splatter from resident tables, chairs, staff feeding stools, walls and wall baseboard heaters. They indicated that they feel rushed and don't have time to clean the identified areas thoroughly. In between these deep cleans both HA's indicated that it is the responsibility of dietary staff to wipe down tables and chairs after each meal service.

A walk through and interview with the General Manager (GM) and the Environmental Services Manager (ESM), both acknowledged the areas of uncleanliness and that the expectation is that the home furnishings and equipment are kept clean and sanitary.

Failure to ensure that the home was kept clean and sanitary may increase the potential for risks associated with infectious diseases, and potentially impacts the resident's right to live in a safe, clean well maintained and comfortable environment.

SOURCES: Observations, interviews with staff, review of policy and procedures, the home's complaint log, and Family Council Meeting minutes.
[115]

WRITTEN NOTIFICATION: Accommodation Services - Maintenance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

RATIONALE AND SUMMARY:
During an Infection Prevention and Control observation tour of the home and additional observations on two other days, the following areas and furnishings were noted to be in a state of disrepair.

Inspector observed the following:
-resident dining room tables and chairs in all neighbourhood dining rooms, showing signs of wear and tear, finish on edges of the tables and arms of the chairs is coming off exposing bare, potentially porous wood.
-vinyl covering on resident dining room chairs in three dining rooms were worn and peeling exposing black foam padding.
-wall damage including torn wallpaper, paint chipped, gouged, and damaged walls throughout the home.
-home's furniture including nursing station desks, couches, chairs, side tables, and fireplace mantles showing signs or wear and tear, discoloured, staining and finish on wood coming off throughout the neighbourhood lounges and parlors.
-wooden handrails throughout all neighbourhoods worn, finish coming off exposing bare, potentially porous wood. Some handrail edges broken exposing potentially sharp edges.

-broken outlet covers were noted in two dining rooms and a neighbourhood hall.
-a tub in the spa room was missing edging exposing rough fiberglass edge.
-a spa room was missing tile at bottom base of the wall.
-a dining room alcohol based hand sanitizer dispenser catch basin was broken off and resting on the handrail

A review of the home's Family Council meeting minutes from last fall, under New Business showed a concern related to some maintenance concerns identified in one of the neighbourhood halls. The Minutes noted action needed and identified that the persons responsible had been notified via email and through a maintenance request.

A review of the home's policy and procedure titled Environmental Services – Objectives for the Department indicated the following:
It is the policy of Schlegel Villages to contribute to the quality of life of the residents by ensuring that their physical environment is clean, safe, well maintained, and comfortable.

A walk through and interview with the General Manager (GM) and the Environmental Services Manager (ESM) both acknowledged the areas and furnishings in disrepair and that the expectation is that the home furnishings and equipment are maintained in a safe condition and in a good state of repair.

Failure to maintain the interior and exterior of the home in a safe condition and a good state of repair had a potential impact on the resident's right to live in a safe, clean and comfortable environment in a dignified matter.

SOURCES: Interviews, observations, complaint records and policies and procedures.

[115]

WRITTEN NOTIFICATION: Training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee failed to ensure that all direct care staff were retrained in 2023 for Infection Prevention and Control and the home's policy to promote zero tolerance of abuse and neglect of residents.

RATIONALE AND SUMMARY:
During an interview the General Manager (GM) confirmed that home did not complete retraining for Infection Prevention and Control (IPAC) and the home's policy to promote zero tolerance of abuse and neglect of residents.

A review of the home's training records showed that only 67 percent of staff completed the Crossroads online education for IPAC and only 73 percent of staff completed the online education for Abuse and Neglect in Long Term Care.

Not ensuring all direct care staff were trained posed a potential risk of staff's knowledge and practice related to IPAC and abuse training.

SOURCES: Interview and staff training records.
[115]

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that medications were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
There was a medication administration error that occurred which resulted in a critical incident being reported to the Ministry of Long-Term Care (MLTC).

During an interview with a Registered Practical Nurse (RPN), they acknowledged that medications were taken by the resident multiple hours earlier than prescribed. The RPN also acknowledged that they did not sign off at the accurate times for the administration of the two of the medications, and that these were not administered at the prescribed time.

There was a risk to the resident's well-being when they were administered medications with sedative effects earlier than specified by the prescriber.

Sources: interview with RPN, the resident's eMAR, and the Medication Administration Audit Report.
[721821]

COMPLIANCE ORDER CO #001 Housekeeping

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (d)
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,
(d) addressing incidents of lingering offensive odours.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must:
Ensure a corrective solution is achieved to address the incident(s) of lingering offensive odours on the neighbourhood.
1. Conduct an assessment as to why current practices have not adequately ensured offensive lingering odours in this area have been addressed.
2. Maintain documented record of this assessment.
3. Based on assessment in part 1, develop and implement a resolution for the lingering offensive odours in this neighbourhood.

Grounds
The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours in one of the home's neighbourhoods.

RATIONALE AND SUMMARY:

During the IPAC tour the inspector noted that there was a urine odour upon entering the neighbourhood, there was a yellow “wet floor” sign placed on an area of the carpet that appeared to be wet.

A few days later the inspector noted that the urine odour was still present upon entering that neighbourhood hall. The inspector stopped a Personal Support Worker in the hall and asked if they could smell the odour and they acknowledged that there were two residents on the unit that inappropriately urinate in the hallway.

The inspector questioned if there were any resident's that were bothered by the smell and they indicated that yes there is a resident that keeps their door closed because of the odour.

Six days later the inspector noted that the urine odour continued to be present.

During an interview conducted with a Personal Support Worker (PSW) they stated that they were aware of the lingering offensive odour in the neighbourhood hall, that there is a resident who is consistently urinating inappropriately in the same area. They indicated that there are residents and family that have also expressed concerns, however the odour continues to persist.

An interview conducted with a Housekeeping Aide (HA) they indicated that they were aware of the lingering offensive odour in this hall and that it’s been ongoing for over a year. The HA stated that there have been ongoing efforts including carpet cleaning using different products in an attempt to alleviate the odour.

A review of the home’s complaint log showed a recent complaint submitted by a

family member of a resident living in the same neighbourhood, about the urine odour in the hallway. The home's complaint tracking noted that this is a repeat complaint and the home's action plan was to clean the carpet daily, using odour neutralizing products.

A review of the home's policy and procedure titled Odour Control indicated the following:
It is the policy of Schlegel Villages to prevent offensive odours where possible and to identify and address incidents of offensive odours that cannot be prevented.
The organized program of housekeeping had a procedure developed and implemented for addressing lingering offensive odours however the odour has not been addressed to the point of being resolved.

During an interview with a resident living on this neighbourhood they indicated that the smell of urine in the hall, forces them to keep their door closed and is unpleasant and bothersome to them. They indicated that they have spoken to staff but have been told it cost too much money to replace the carpet.

During an interview with the General Manager (GM) they acknowledged that the odour remained despite the effort of the staff to clean and eliminate the odour and that it should be addressed. They explained that plans to replace carpeting in the neighbourhoods is ongoing but that this neighbourhood was not identified as the next neighbourhood to undergo replacement.

Offensive and lingering odours pose an infection prevention and control issue, and create an unpleasant living environment for residents and visitors.

SOURCES: Observations, interviews with staff and residents, review of policy and procedures, the home's complaint log, and Family Council Meeting minutes.

[115]

This order must be complied with by May 24, 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
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.