

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**

**Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre
Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 3, 2021	2021_800532_0004	022074-20, 023329- 20, 023402-20, 000861-21, 001693-21	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

The Village at University Gates
250 Laurelwood Drive Waterloo ON N2J 0E2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

NUZHAT UDDIN (532), SARAH INGLIS (767)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 28-29 and February 1-4, 2021.

The following intakes were completed during this inspection:

Log #000861-21, Log #023402-20 and Log #023329-20, related to falls prevention; Log #001693-21, related to a COVID-19 outbreak; and Log #022074-20, related to resident care.

During the course of the inspection, the inspector(s) spoke with the General Manger (GM), Director of Nursing Care (DNC), Assistant Director of Nursing Care (ADNC), Neighbourhood Coordinator (NC), Public Health inspector, Resident Assessment Instrument Coordinator (RAI-C), Kinesiologist, Registered Nurses, (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeper and residents.

The inspectors also toured resident home areas, observed resident care provision, dining observations, and resident to staff interaction; and reviewed relevant residents' clinical records.

The following Inspection Protocols were used during this inspection:

**Falls Prevention
Infection Prevention and Control
Reporting and Complaints**

During the course of this inspection, Non-Compliances were issued.

2 WN(s)

1 VPC(s)

2 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised, (a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care related to falls prevention was provided to a resident as specified in the plan.

A resident's plan of care directed staff to provide specific strategies to prevent falls.

An incident occurred where supervision and oversight was not provided as outlined in the plan of care for the resident, which resulted in injury to the resident.

Sources: CIS, progress notes, care plan, falls risk assessment and interviews with the ADNC, PSW, and other staff. [s. 6. (7)]

2. The licensee failed to ensure that a resident's plan of care related to falls prevention was revised when care set out in the plan of care was not effective, and that different approaches were considered.

A resident was at risk of falls and had a number of falls in one month.

No revisions were made to the resident's plan of care to address concerns surrounding trip hazards. Failing to update the resident's plan of care in relation to these hazards put the resident at risk for having additional falls and injuries.

Sources: CIS, progress notes, care plan, falls assessments and interviews with staff, and others. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the home's infection prevention and control program in relation to donning and doffing personal protective equipment (PPE) and sanitizing equipment.

a) During Infection Prevention and Control observations it was noted that an essential caregiver entered a unit without reading the infection prevention and control signage posted at the entrance of the unit. The signage stated that the unit was on contact and droplet precautions and that individuals were required to don a face shield and gown prior to entering a resident's room. The essential caregiver was then observed entering a resident's room while only wearing a mask.

b) Staff members were observed going in and out of resident rooms and walking in unit hallways without removing their gowns.

The home's Infection Prevention and Control policy, stated that all PPE should be removed when leaving a resident's room to ensure the corridor did not become contaminated.

c) A personal protective equipment (PPE) cart and mechanical lift were observed to be missing disinfectant wipes. Staff said that when this occurred, they used alcohol-based hand rub (ABHR) and paper towels to disinfect their face shields and the lifts. They said the wipes had been missing from the mechanical lift for over a month.

ABHR is recommended for personal hand hygiene to help prevent the spread of pathogens and infections in health care settings.

The breach of infection prevention and control practices increased the risk of infectious disease transmission throughout the home.

Sources: observations, interviews with a Public Health Inspector, and a General Manager, and review of the home's Pandemic Preparedness policy. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 4th day of March, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : NUZHAT UDDIN (532), SARAH INGLIS (767)

Inspection No. /

No de l'inspection : 2021_800532_0004

Log No. /

No de registre : 022074-20, 023329-20, 023402-20, 000861-21, 001693-21

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Mar 3, 2021

Licensee /

Titulaire de permis : Schlegel Villages Inc.
325 Max Becker Drive, Suite. 201, Kitchener, ON,
N2E-4H5

LTC Home /

Foyer de SLD : The Village at University Gates
250 Laurelwood Drive, Waterloo, ON, N2J-0E2

Name of Administrator /

**Nom de l'administratrice
ou de l'administrateur :** Shelley Edwards-Dick

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

To Schlegel Villages Inc., you are hereby required to comply with the following order
(s) by the date(s) set out below:

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Order # /**No d'ordre :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA, 2007.

Specifically, the licensee must:

- 1) Ensure that residents that are at high risk for falls receive care as set out in the plan of care in relation to falls prevention.
- 2) Ensure that residents that are at high risk for falls are audited on a monthly basis for six months to ensure that interventions for falls prevention are implemented. These audits should include the auditing schedule, the name of the Manager or designate conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results. The written audit must be kept available in the home.

Grounds / Motifs :

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

1. 1. The licensee has failed to ensure the care set out in the plan of care related to falls prevention was provided to a resident as specified in the plan.

A resident's plan of care directed staff to provide specific strategies to prevent falls.

An incident occurred where supervision and oversight was not provided as outlined in the plan of care for the resident, which resulted in injury to the resident.

Sources: CIS #3048-000029-20, progress notes, care plan, falls risk assessment and interviews with the ADNC, PSW, and other staff. [s. 6. (7)]

An order was made by taking the following factors into account:

Severity: Supervision and oversight were not provided as outlined in the resident's plan of care, which resulted in actual harm to the resident.

Scope: The scope of this non-compliance was isolated because one out of three residents reviewed did not receive care as set out in the plan of care.

Compliance History: One written notification (WN) and one voluntary plan of correction (VPC) were issued to the home related to this section of legislation in the past 36 months. (532)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

May 04, 2021

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Order # /

No d'ordre : 002

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,

(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee must be compliant with s. 6 (11) of the LTCHA, 2007.

Specifically, the licensee must:

1) Ensure that when a resident's plan of care is being revised because the care set out in the plan of care has not been effective in relation to falls prevention and management, that different approaches are considered and revisions are made to the plan of care.

Grounds / Motifs :

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

1. 1. The licensee failed to ensure that a resident's plan of care related to falls prevention was revised when care set out in the plan of care was not effective, and that different approaches were considered.

A resident was at risk of falls and had a number of falls in the one month.

No revisions were made to the resident's plan of care to address concerns surrounding trip hazards. Failing to update the resident's plan of care in relation to these hazards put the resident at risk for having additional falls and injuries.

Sources: CIS #3048-000002-21, progress notes, care plan, falls assessments and interviews with staff, and others. [s. 6. (11) (b)]

An order was made by taking the following factors into account:

Severity: Failing to consider different approaches in the revision of the resident's plan of care in relation to falls prevention resulted in actual harm to the resident.

Scope: The scope of this non-compliance was isolated as one out of three residents reviewed did not have different approaches considered in the revision of their plan of care.

Compliance History: Three WNs and three VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months. (767)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

May 04, 2021

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX
APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or
section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

Aux termes de l'article 153 et/ou de
l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière
d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3rd day of March, 2021

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Nuzhat Uddin

Service Area Office /

Bureau régional de services : Central West Service Area Office