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 West District
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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: November 1, 2022

Inspection Number: 2022-1476-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village at University Gates, Waterloo

Lead Inspector	**Inspector Digital Signature**
Nuzhat Uddin (532)	Nuzhat Uddin Digitally signed by Nuzhat Uddin Date: 2022.11.03 10:30:10 -04'00'

Additional Inspector(s)
Alicia Campbell (741126)
Kim Byberg (729)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 3, 2022
October 4, 2022
October 5, 2022
October 6, 2022
October 7, 2022
October 11, 2022

The following intake(s) were inspected:
- Intake : #00001760- concerns regarding medication management and plan of care.
- Intake: #00004023- Potential improper transfer of a resident.
- Intake: #00006225- Concerns re medication management and plan of care.

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

Medication Management
Infection Prevention and Control
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 (1) (c)

Non-compliance with: FLTCA, 2021 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
A resident's care plan listed an intervention as a strategy to deter responsive behavior during transfers that was part of a falls prevention strategy.

Several staff members said that they had tried the intervention; however, it was not successful; while others said that the required equipment to use the intervention was not available. Two staff said that the intervention should be available for staff, if required.

Neighborhood Coordinator indicated that the intervention was not accessible to staff and was placed back in the resident's room.

There was risk that unclear direction to staff regarding the location and use of the intervention as a strategy could prevent them from utilizing the strategy that may reduce the risk of an injury to the resident.

Sources: interviews with PSWs, PERT recreation staff, RAI Coordinator; resident's care plan; resident's progress notes; resident's PERT referral and assessment; observations of resident's room.

[741126]

WRITTEN NOTIFICATION: Directives by Minister
NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

Non-compliance with: FLTCA, 2021. s.184(3)

The licensee has failed to ensure that staff carried out every operational or policy directive that applied to the long-term care home when staff were observed not following the recommended guidelines for Personal Protective Equipment (PPE) use when interacting with residents that had suspected COVID-19.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, the licensee was to ensure that the PPE requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, were complied with. The COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities, revised June 10, 2022, indicated all health care workers that provided direct care to or interacted with, a suspect or confirmed case of COVID-19 should wear eye protection (goggles, face shield, or safety glasses with side protection), gown, gloves, and a fit tested, seal-checked N95 respirator (or approved equivalent).

Rational and Summary

A covid-19 outbreak was confirmed at the home on September 21, 2022.

A staff member was observed exiting a resident room and did not have on their face shield or other eye protection. They did not change their N95 mask as part of their doffing PPE process.

The door to the shared accommodations had droplet contact signage that instructed staff to wear a mask and eye protection within two meters of a resident, to wear gloves and a long-sleeve gown for direct care.

A staff stated that they were providing care to a resident and the resident was not confirmed covid-19 positive; but the resident's roommate had tested positive for covid-19.

The home's IPAC lead, and the public health consultant stated that eye protection and/or face shield must be worn when entering a resident room that is on droplet contact precautions. The home's IPAC lead confirmed that when a face shield was not worn, the staff member would be required to change their N95 mask.

When the staff member was not wearing facial protection and did not doff their N95 after providing

direct care to a resident in isolation and under droplet contact precautions for suspect covid-19, may have increased the risk of transmission of covid-19 to other residents, staff, and visitors throughout the home.

Sources: Interview with Public Health Consultant, IPAC Lead, registered staff. Observations, record review of COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities Version 1.0 June 10, 2022; Minister's Directive: COVID-19 response measures for long-term care homes Effective August 30, 2022, the homes donning and doffing signage and droplet contact precautions signage.

[729]

WRITTEN NOTIFICATION: Plan of Care
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident's substitute decision-maker (SDM), was given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan.

Rational and Summary

A complaint was received related to an incident where a resident experienced a rapid health decline. The SDM said they were not notified of the changes in regard to resident's health status and they had concerns related to the administration of medication.

The resident's substitute decision maker was not notified of the change in the resident's health status.

Registered Nurse (RN) acknowledged that they did not notify the SDM until the resident health status changed significantly.

Director of Nursing Care (DNC) stated the resident's SDM should have been called earlier and they should have been provided with an opportunity to participate in the development and implementation of the resident's plan of care.

Failure to communicate with the SDM regarding the change in resident's condition, prevented the SDM from participating in their plan of care and their exclusion from the residents plan of care placed the resident at moderate risk of harm.

Sources: Progress notes, prescriber orders sheet, electronic medication administration record (e MAR), assessment, interview with RN and DOC.
[532]

WRITTEN NOTIFICATION: Medication Management System
NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 123 (2)

The written policies and protocols must be developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rational and Summary

The physician's order policy indicated that phone orders were given by the physician to the registered team member. These orders were to be written on the physician's order sheet by the registered team member who received the order.

Specifically, the policy stated that the following steps were to be completed:
-The registered team member will share all residents at handover to oncoming registered team members to alert all team members to a new order to ensure that second check has been completed.
-Date and initial the order has been processed.
-The second registered team member will double check the order is processed correctly.

A resident had a change in health status. The physician was called, and orders were received to administer medication.

The order was not processed as directed by policy.

There was a moderate risk of harm when the order processed based on the home's policy.

Sources: Physician's order policy, progress notes, prescriber orders sheet, electronic medication administration record (e MAR), assessment, interview with ADNC.

[532]

COMPLIANCE ORDER CO #001

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The Inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The Inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

A) Ensure the home's signage includes direction for staff on disinfecting reusable eye wear or face protection as part of the home's procedure for doffing PPE. PHO signage may be utilized. Ensure that the signage is readily available to staff and included in the home's outbreak management program.

B) Ensure staff members working on specified Neighborhood are provided with education on the home's policy titled "disinfecting of goggles, face shields and glasses" in the infection prevention and control manual.

C) Ensure that the specified PSW is re-educate on the donning and doffing procedures.

D) Ensure that a copy of the education is kept in the home and includes the staff members names, designation, the title of the education, copy of the education provided, date the education was provided as well as who completed the education.

E) Conduct weekly audits for one month following the training to ensure that disinfecting of goggles, face shields and glasses" is occurring as per the home's policy. Written documentation of the audit including the person who conducted the audit, what was reviewed in the audit, date the audit was conducted, the outcome of the audit, and corrective actions taken must be maintained in the Home.

Grounds
Non-compliance with: O. Reg. 246/22 s.102(2)(b)

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

According to O. Reg 246/22, s.102 (2)(b), the licensee was required to implement any standard or

protocol issued by the Director with respect to IPAC. 1. The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 9.1, documented that the licensee shall ensure that routine practices and additional precautions were followed in the IPAC program. At minimum, routine practices shall include b) hand hygiene, including, but not limited to, at 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. At minimum, additional precautions shall include f) additional PPE requirements including appropriate selection, application, removal, and disposal.

- A PSW exited resident's room, removed their gloves and gown, rolled up the gown and put it under their arm, walked to the end of the hallway and disposed of the gown in a dirty garbage bin. A resident was on droplet contact precaution isolation. PSW stated that they should have disposed of the gown and gloves in the garbage can in the resident room.

-A PSW and a secondary PSW exited resident's room that was under isolation and on droplet contact precautions. PSW and the secondary PSW did not change or clean their face shield as part of their doffing PPE process. The PSW did not perform hand hygiene after doffing and disposing PPE. The PSW then entered resident room that was in isolation and on droplet contact precautions, they exited the room doffed PPE, did not clean or change face shield before entering a third resident room that was in isolation and on droplet contact precautions.

-A registered staff member came out of resident room that was in isolation and on droplet contact precautions. As they walked down the hall they removed their gown, and gloves and disposed of the PPE in another resident room at the end of the hallway. They did not perform hand hygiene or clean/change face shield. After completing a task at the nursing station, they then re-entered room with new PPE on. When they exited the room a second time, they doffed their PPE, and did not clean/change their face shield.

Resident room number of resident rooms all had droplet contact signage on the doors and signage instructing staff on the home's process for removing PPE. The signage for removing PPE did not include the steps to change or clean their eye/face protection.

PSW stated they were to clean their face shield between residents.

Public Health stated staff needed to clean or change their face shields between each resident and abide by the contact time of the disinfectant used to clean the shields.

When staff did not perform hand hygiene and follow the PPE requirements of removal and disposal of

PPE after interacting with residents that were isolated and under droplet contact precautions, they may have increased the risk of transmission of covid-19 to other residents, staff and visitors throughout the home.

Sources: COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units Version 7 – June 27, 2022; A Resource for Health Care Workers Cleaning and Disinfection of Reusable Eye Protection; Policy titled: Hand Hygiene Tab 06-13 effective 07/14/2021; Policy titled: Disinfecting of goggles, face shields and glasses tab 06-22.

[729]

This order must be complied with by December 9, 2022

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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.