Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: March 23, 2023	
Inspection Number: 2023_1476_0003	
Inspection Type: Critical Incident (CI) Complaint Inspection (#2023_1476_0004) occurred concurrently with this CI inspection	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village at University Gates, Waterloo	
Lead Inspector Katherine Adamski (#753)	**Inspector Digital Signature**
The following additional inspectors were also present for this inspection: Mark Molina (#000684) Gabriella Del Principe (#741734) Sharon Perry (#155) Kailee Van Del Vegte (#000734)	

INSPECTION SUMMARY

The inspection occurred on the following dates:
February 27, 28, March 1-3, 6-10, 2023.

The following intakes were inspected:
- Intake: #00002109 - related to falls prevention and management
- Intake: #00006891, #00008304, and #00011643 - related to resident neglect
- Intake: #00018288 - related to visitor to resident physical abuse
- Intake: #00020087 - related to staff to resident physical abuse
- Intake: #00020144 - related to improper transfer/positioning of a resident

The following intakes were completed in this inspection: #00003132 and #00004577 - related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control

Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 56 (2) (g)

The licensee failed to ensure that two residents, who required continence care products, had sufficient changes to remain clean, dry and comfortable.

Rationale and Summary

A) A resident was incontinent, they required assistance from staff, a continence care product, and to be to be checked and changed to keep the resident's skin clean and dry in order to provide comfort and prevent skin breakdown.

The resident was found with their continence care product soiled.

The Administrator acknowledged that resident #003 was not provided sufficient changes to their continence care product as required by their plan of care.

When the resident was not checked and changed as required to keep them clean, dry, and comfortable, they were at risk of developing skin concerns.

Sources: The residents' plan of care including care plan, progress notes, Point of Care (POC) task documentation, interviews with staff.

B) A resident had pre-existing skin concerns, they were incontinent, required a continence care product, assistance from staff, and to be checked and changed.

The resident was found with their continence care product soiled. The resident reported that staff had not checked them that night.

When the resident was not provided sufficient changes to remain clean, dry and comfortable, they

were at risk of developing complications including infection due to the severity of their pre-existing skin concerns.

Sources: The residents' plan of care including care plan with revision history, progress notes, Resident Assessment Instrument (RAI) - Minimum Data Set (MDS) assessments, assessment tab in Point Click Care (PCC), POC task documentation, interviews with staff.

WRITTEN NOTIFICATION: PLAN OF CARE

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

The licensee failed to ensure that there was a written plan of care that sets out the planned care for the resident.

Rationale and Summary

A resident had a physical altercation with a visitor, the home stated that they would put all visits with this individual on hold.

The residents' plan of care was not updated to reflect the visitation restrictions and the visitor continued to visit the resident resulting in more incidents that required staff to intervene. These additional incidents put the resident at risk of harm by the visitor.

Sources: The residents' plan of care including current kardex, care plan with revision history, physical chart, progress notes, interviews with staff.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 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 the care set out in the plan of care was provided to a resident as specified in their plan in relation to personal expressions.

Rationale and Summary

Resident #005 had a history of personal expressions and their care plan included special instructions for staff when providing care to the resident.

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A Personal Support Worker (PSW) did not follow the resident's plan of care, and this resulted in an allegation of staff to resident abuse.

When the PSW did not follow the residents' plan of care, the resident did not receive the support they required related to their personal expressions.

Sources: The residents' plan of care including care plan with revision history, kardex, progress notes, interviews with staff.

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary

Observations on three separate neighborhoods including Johnston, Downey, and Matthews showed unsupervised doors to the shower rooms were neither closed nor locked to restrict access to residents.

The floor in the Johnston shower room was wet, and no wet floor sign was observed at the time of the observation. All three shower rooms contained hazardous chemicals including multiple bottles of disinfectant solutions, as well as other potentially harmful items.

All three direct staff interviewed acknowledged that the door to the shower room should be closed, additionally, two PSW's stated that it was common practice to leave the doors open to release steam and allow the floor to dry.

When the doors leading to the shower room were not closed and locked, there was a risk of residents wandering in and injuring themselves.

Sources: Observations, interviews with staff.

[#753]