Original Public Report

Report Issue Date: October 18, 2023	
Inspection Number: 2023-1476-0007	
Inspection Type: Complaint Critical Incident	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village at University Gates, Waterloo	
Lead Inspector Josee Snelgrove (#674)	**Inspector Digital Signature**
Additional Inspector(s) Katherine Adamski (#753) Amanpreet Kaur Malhi (#741128)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 19-22, 25-29, 2023.

The following Critical Incident (CI) intake(s) were inspected:
- Intake: #00093321 - Related to Falls Prevention and Management
- Intake: #00093355, #00096147, #00096414 - Related to allegations of Abuse or Neglect

The following Complaint intake(s) were inspected:
- Intake: #00093592 - Related to Nutrition and Hydration
- Intake: #00094287 - Related to Skin and Wound Care

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)

The licensee has failed to ensure that suspected abuse of a resident was immediately reported to the Director.

Rationale and Summary

An incident of alleged abuse was reported to the Director, along with several other reportable incidents that had not been previously reported. Direct care staff stated that they had immediately reported these incidents to the leadership team.

The Assistant General Manager (AGM) stated that it was the home's responsibility to immediately report these incidents to the Director and that they had failed to do so.

The failure to immediately report suspected abuse to the Director impacted their ability to immediately respond, if required.

Sources: Critical Incident Reports, resident progress notes, the home's internal investigation notes, interviews with AGM and other staff. [#753]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021, s. 24(1)

The licensee shall:

A) Provide ADNC #115 re-education on the home's Prevention of Abuse and Neglect Policy specifically related to identifying situations which constitute emotional or physical abuse, and ensuring care plans of residents are reviewed and revised to include appropriate interventions for ensuring the resident's

safety. A record of the education should be kept in the home including the date, any corrective action, format and the name of the staff member who provided the education.

B) Develop and implement a system to ensure that the Personal Expression Resource Team (PERT) Lead reviews and takes immediate action, as necessary, to incidents of suspected, alleged or witnessed abuse or neglect.

C) Audit the system as outlined in B), to ensure that incidents are being reviewed and actioned in a timely manner. The audit should include the date, person completing the audit, incident description, date incident occurred and was reviewed, action taken in response and the date. Conduct the audit weekly for a minimum of one month, or until such time that compliance is achieved.

Grounds

The licensee failed to protect a resident from emotional and physical abuse.

Section 2 (1) of the Ontario Regulation 246/22 (O. Reg. 246/22) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Section 2 (1) of the Ontario Regulation 246/22 (O. Reg. 246/22) defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary

Incidents of abuse occurred between a resident and another person that put the resident at risk of harm.

The AGM stated that it was the Personal Expression Resource Team (PERT) Lead's responsibility to review incident notes to identify potential incidents of abuse, investigate, and respond to incidents. This included communicating these incidents during the monthly PERT meetings, so that a plan could be implemented. The PERT Lead failed to ensure this was done.

Interventions in place at the time were ineffective as subsequent incidents occurred that caused emotional and physical distress to the resident.

Direct care staff stated that interventions were not effective for ensuring resident safety because they were difficult to implement on a continuous basis.

Failure to protect the resident from abuse by another person caused emotional and physical distress.

Sources: the home's internal investigation notes related to Critical Incident Reports, email communication with Police, resident's special instructions, care plan, assessments, progress notes, incident reports, the home's internal investigation notes, interviews with AGM and other staff. [#753]

This order must be complied with by December 1, 2023

COMPLIANCE ORDER CO #002 Behaviours and Altercations

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg. 246/22, s. 60 (a)

The licensee shall:

A) Review and revise the Code White Violent Resident Situation Policy to include specific direction on when and how staff are to monitor/manage a resident while when behaviours put other residents and staff at risk of harm.

B) Facilitate a meeting to review the incident in question with all staff involved for the purposes of learning. This meeting should include a review of strategies for de-escalating residents who are behaving in a potentially dangerous/harmful manner towards themselves or others, while protecting vulnerable residents in the vicinity and the appropriate time to announce a Code White.

C) Document the education, as outlined in B), including the date, format, staff who attended, and the staff member who provided the education.

Grounds

The licensee failed to ensure that procedures and interventions which were developed, to assist staff who were at risk of harm or who were harmed as a result of a resident behaviours and to minimize potentially harmful interactions between and among residents were implemented.

Rationale and Summary

A resident had exhibited responsive behaviours which harmed a resident and staff. Staff did not follow the home's Code White Violent Resident Situation Policy.

The home's Code White Violent Resident Situation Policy stated that the Team Member(s) involved shall

immediately direct all Residents away from potential conflict or danger related to the identified individual and required that a code white be announced immediately.

The failure of staff to implement interventions that had been developed in response to the resident's responsive behaviours left both staff and residents vulnerable to the harmful interactions.

Sources: Critical Incident (CI) report; Code White related to Violent Resident Situation Policy; Clinical records for residents; interview with staff. [#674]

This order must be complied with by December 1, 2023

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.