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
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: December 28, 2023

Inspection Number: 2023-1476-0008

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Schlegel Villages Inc.

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

Lead Inspector	**Inspector Digital Signature**
Janis Shkilnyk (706119)	Janis Shkilnyk Digitally signed by Janis Shkilnyk Date: 2023.12.29 11:37:06 -05'00'

Additional Inspector(s)
Megan Brodhagen (000738)
Craig Michie (000690)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 12,-15, 18-21, 2023

The following intake(s) were inspected:

- Intake: #00097613 /Intake: #00099061 - Fall of a resident with injury
- Intake: #00097793 - allegation of resident abuse
- Intake: #00098249 - Complaint related to an allegation of resident abuse and care concerns
- Intake: #00098809 - infectious disease outbreak

- Intake: #00099667 - Follow-up # 001 FLTCA 2021 s. 24 (1)
- Intake: #00099666 - Follow-up #002 O. Reg. 246/22 s. 60 (a)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1476-0007 related to FLTCA, 2021, s. 24 (1) was complied.
Order #002 from Inspection #2023-1476-0007 related to O. Reg. 246/22, s. 60 (a) was complied.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Food, Nutrition and Hydration
Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that cleaning and disinfection of contact surfaces was followed in accordance with evidenced based practices.

Rationale and Summary

Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), best practices for environmental cleaning for prevention and control of infections in all health care settings, 3rd edition, revision April 2018, recommended when using disinfectant, there should be systems in place to ensure the efficacy of the disinfectant over time, such as reviewing the expiry dates.

It was observed that the concentrated disinfectant in two resident home areas had expired. Staff changed out the expired bottles of the concentrated disinfectant to product that was not expired.

The Director of Environmental Services acknowledged that there was a gap and no process where expiry dates were checked and documented. The Director of Environmental Services created a new audit document for staff members to use to check cleaning and disinfectant products expiration dates weekly upon delivery and monthly once on the home areas.

Sources:

Observations of Housekeeping supply areas, Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), best practices for environmental cleaning for prevention and control of infections in all health care settings, 3rd edition, revision April 2018, and Interview with Director of Environmental Services

[000738]

Date Remedy Implemented: December 13, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to comply with signage, listing the required infection control precautions at the entrance to a resident's room or bed space. Provincial Infectious Diseases Advisory Committee (PIDAC): Routine Practices and Additional Precautions in All Health Care Settings, November 2012, states signage specific to the type(s) of additional precautions should be posted: A sign that lists the required precautions should be posted at the entrance to the client/patient/resident's room or bed space.

Rationale and Summary

A resident was positive for an infectious disease and determined to require precautions.

No signage was observed on the resident's bedroom door.

The Infection Prevention and Control (IPAC) Lead stated that they were unsure why the additional precaution signage was taken down but would put new additional precaution signage on the resident's bedroom door.

There was no impact and low risk to the residents as there was Personal Protective Equipment (PPE) available for staff and visitor use and signage was posted by the IPAC Lead.

Sources:

Observations of a resident, interview with IPAC Lead, PIDAC: Routine Practices and Additional Precautions in All Health Care Settings, November 2012.

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Date Remedy Implemented: December 12, 2023

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
Involvement of resident, etc.
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care when they were not notified of a resident's change of condition.

Rationale and Summary

Documentation indicated a resident had a change in health status. The substitute decision maker (SDM) was not notified at the time the change was discovered.

A registered staff member confirmed that the resident's SDM was not notified of the resident's change of condition and should have been.

The resident's SDM was not notified of their change in condition and thus were not able to fully participate in the development and implementation of the plan of care.

Sources:

Interview with staff, review of the resident's clinical records, investigative notes, critical incident review.

[706119]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to immediately forward to the Director a written complaint that it received concerning the care of a resident.

Rationale and Summary

The home received a written complaint of an allegation of resident abuse and care concerns related to a resident.

The Director of Care (DOC) stated that the written complaint was not forwarded to the Director immediately.

The home's failure to notify the Director immediately of the written complaint could have led to potential risk for the resident by not investigating all aspects of the alleged allegations of abuse and care concerns towards the resident.

Sources:

Interview with DOC, a resident's clinical records, home's investigative notes, written complaint.

[706119]

WRITTEN NOTIFICATION: Directives by Minister

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to carry out every operational or policy directive that applies to the long-term care home.

Rationale and Summary

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated November 7, 2023, homes must complete Infection Prevention and Control (IPAC) audits weekly when a home is in an infectious disease outbreak.

An infectious disease outbreak was declared at the home and continued for a period of time. The home was to conduct IPAC Self-Assessment Audits, but they were not completed four out of the six weeks the home was in outbreak.

The IPAC Lead confirmed that the required audit was not completed weekly.

In failing to complete the required weekly IPAC Self-Assessment Audits during an infectious disease outbreak, the home placed residents at potential risk for infection and prolonged outbreak.

Sources:

Record review of the home's PHO IPAC Self-Assessment Audits and IPAC Checklist, Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario, interview with IPAC Lead.

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WRITTEN NOTIFICATION: Foot care and nail care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (1)
Foot care and nail care
s. 39 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The licensee has failed to ensure that a resident received foot care to maintain comfort and prevent infection.

Rationale and Summary

A resident required total assistance with toenail care.

The resident's toenails were found to require care.

The Director of Care (DOC) stated that the resident had not been provided toenail care.

By not providing the necessary assistance for toenail care, there was potential impact to the resident's comfort and risk of infection.

Sources:

A resident's clinical health records, critical incident, the home's investigation notes related to a complaint; Interviews with DOC.

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WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that when a resident exhibited altered skin integrity, a skin assessment by a member of the registered nursing staff, using a

clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, was completed.

Rationale and Summary

An alteration to skin integrity was noted for a resident. There was no initial skin assessment conducted in relation to this alteration.

The home's Skin and Wound Lead stated an initial skin assessment should have been completed for the resident.

The home's failure to complete an initial skin and wound assessment for a resident when an alteration in skin integrity was identified could have impacted treatment and thus the healing of the skin condition.

Sources:

A resident's clinical records, interview with Skin and Wound Lead, Registered Practical Nurse (RPN, investigation interviews

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WRITTEN NOTIFICATION: Skin and wound care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while

asleep if clinically indicated; and

The licensee has failed to ensure that a resident was repositioned every two hours.

Rationale and Summary

A resident required extensive assistance for repositioning.

The resident was not observed to be repositioned for more than two hours.

Staff stated the resident would be repositioned after the next meal.

The Skin and Wound Lead stated that they would expect the resident to be repositioned every two hours.

When the resident was not repositioned every two hours, there was potential impact to their health status.

Sources:

A resident's clinical health records, observations of the resident, interviews with staff.

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WRITTEN NOTIFICATION: Continence care and bowel management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan

of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that the continence plan of care was implemented for a resident.

Rationale and Summary

The resident required total assistance with their continence needs.

The resident's continence assessment and care plan documented continence care were to be given at specific times.

The resident was not provided continence care as documented in their clinical records.

Staff stated that the resident had not been provided continence care during the time observed.

The home's failure to follow the continence plan for a resident would have delayed their continence care and may have an impact on their skin integrity.

Sources:

Observations of the resident, review of the resident's clinical records, and interview with staff.

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WRITTEN NOTIFICATION: Menu planning

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (b)

Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and

The licensee has failed to ensure that a resident received a between-meal beverage in the morning.

Rationale and Summary

A resident required staff assistance with eating and drinking.

A resident was not assisted with a between-meal beverage on two occasions.

By not providing the resident with a between-meal beverage, there was potential impact to the resident's health status.

Sources:

A resident's clinical health records, observations of a resident, interviews with staff.

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