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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Original Public Report

Report Issue Date: April 11, 2024
Inspection Number: 2024-1476-0003
Inspection Type: Critical Incident
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village at University Gates, Waterloo

Lead Inspector	**Inspector Digital Signature**
Brittany Nielsen (705769)	Brittany Nielsen Digitally signed by Brittany Nielsen Date: 2024.04.15 11:53:46 -04'00'

Additional Inspector(s)
Bhavin Mistry (000863) was present throughout the inspection

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 25-28 and April 2, 2024

The following intake(s) were inspected:

- Intake: #00108976 - related to a resident to resident altercation
- Intake: #00112271 - related to a disease outbreak

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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 failed to ensure that the Infection Prevention and Control (IPAC) Standard issued by the Director, was implemented.

A) The licensee failed to ensure that staff removed and disposed personal protective equipment (PPE) correctly when exiting resident rooms that were on additional precautions.

According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated April 2022, section 9.1 directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program, specifically 9.1 (f) referring to proper use of PPE, including appropriate selection, application, removal, and disposal for additional precautions.

Rationale and Summary

The Inspector observed a staff member come out of two resident rooms who were on additional precautions. Upon exit of the room, the order the staff member removed their PPE was gown, shield, and then gloves.

A staff member came out of two resident rooms who were on additional precautions and discarded their used PPE inside a garbage that was not dedicated for that.

There was an outbreak declared on the Neighbourhood at the time.

Staff said the order the PPE should have been removed was gloves, gown, and then face shield and the used PPE should have been discarded in a dedicated garbage in the resident's room.

By not removing and disposing PPE correctly, there was risk of transmission of infectious agents.

Sources: observations of staff IPAC practices, interviews with staff, and record review of the IPAC Standard for LTCHs dated April 2022.
[705769]

B) The licensee failed to ensure that staff performed hand hygiene at the four moments of hand hygiene.

According to the IPAC Standard for LTCHs dated April 2022, section 9.1(b) directs staff to perform hand hygiene at the four moments of hand hygiene, which includes before and after contact with the resident and/or the resident's environment.

Rationale and Summary
The Inspector observed a staff member assist a resident with the placement of their spoon in their hand. The staff did not perform hand hygiene prior to continuing to

serve desserts.

A staff member handled dirty dishes and then assisted another resident with their drink without performing hand hygiene in between.

Five staff members donned a clean mask without performing hand hygiene after assisting residents with their meal.

A staff member came out of a resident's room on a Neighbourhood that was in an outbreak. The staff member removed their gloves, but did not perform hand hygiene.

Staff acknowledged that hand hygiene should be performed after coming in contact with the resident and their environment.

By failing to follow the IPAC Standard and not performing hand hygiene as per routine practices, there was risk of transmission of infectious agents.

Sources: observations of IPAC practices, interviews with staff, and record review of the IPAC Standard for LTCHs dated April, 2022.
[705769]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from physical abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

Rationale and Summary
A resident hit another resident, causing injury.

By failing to protect a resident from abuse, a resident was physically injured.

Sources: a resident's progress notes and interviews with staff.
[705769]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

The licensee failed to ensure that staff followed the home's Managing a Respiratory Outbreak policy, while a Neighbourhood was in an outbreak.

As per O. Reg. 246/22, s. 11 (1) (b), the licensee shall ensure that where the Act or

Regulations required the licensee of a long-term care home to have, institute, or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

The home's Managing a Respiratory Outbreak policy directed staff to clean ill rooms last.

Rationale and Summary
The Inspector observed a staff member clean two rooms on a Neighbourhood that was in an outbreak that were on additional precautions before cleaning a resident's room that was not on additional precautions.

Staff said rooms on additional precautions should be cleaned last.

By failing to follow the Managing a Respiratory Outbreak policy, there was risk of further transmission of infectious agents.

Sources: observations of IPAC practices, interviews with staff, and Record review of the Managing a Respiratory Outbreak policy, 04-05.
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