Ontario

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

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

Original Public Report

Report Issue Date: October 22, 2024
Inspection Number: 2024-1476-0006
Inspection Type: Proactive Compliance Inspection
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village at University Gates, Waterloo

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 19-20, 24-27, 2024 and October 1-4, 7-8, 2024

The following intake(s) were inspected:

- Intake: #00127052 - PCI Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards

Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Dealing with complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

Rationale and Summary

The home received a written complaint regarding the open concept servery.

A Substitute Decision Maker (SDM) raised concerns regarding the open concept kitchen/dining area. They stated that on several occasions they witnessed residents entering the service area and touching the cutlery. The SDM further stated they were not in agreement of residents entering this area. They expressed concerns but were not aware of whether any action was taken.

The written complaint was reviewed by the leadership team but not investigated or resolved within 10 business days of the receipt of the complaint.

Food Service Manager (FSM) acknowledged that they did not follow-up on the complaint when they became aware of it.

Failure to pursue the complaint increased the risk of harm to residents.

Sources: Review of complaint, observations and Interview with the SDM and FSM.

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

Rationale and Summary

A resident had a diagnostic test revealing some areas of concerns.

An order was received to treat the concern. However, the staff withheld the drug without informing the Nurse Practitioner (NP).

For a specified time frame the resident showed signs and symptoms of pain.

A new “stat “order for the drug was issued and was administered.

Resident was relived of pain and appeared relaxed and calm.

RPN and RN both reported that the drug should have been administered as ordered by the NP and should not have been withheld by the nursing staff.

When the drug was not administered in accordance with the directions for use specified by the prescriber, the resident was at increased risk of ineffective pain management.

Sources: Observations review of physicians' order, and clinical record review, interview with SDM and registered staff.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that a copy of the continuous quality improvement initiative report was provided to Residents' Council.

Rationale and Summary

The Continuous Quality Improvement (CQI) Initiative Report was not provided to the Residents' Council.

When the licensee failed to share the CQI Initiative report with the residents' council, the council was denied an opportunity to be fully informed of the CQI initiatives and the home's plan to address them.

Sources: Residents' Council meeting minutes (October 2023-September 2024), Email communication with the Director of Quality and Innovation, and Interviews with the Director of Quality and Innovation and the Resident Support Coordinator.

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must be compliant with the FLTCA, 2021, s. 5. Specifically, the licensee must complete the following:

1, Replace all hot water dispensing units that are accessible to residents with a model that cannot dispense hot water by simply pressing a button.
2., Choose one of the following options and complete the tasks under the chosen option:

Option #1:

1. Install a sliding or swing gate that is equipped with a type of latch or lock that cannot be easily manipulated by a resident (i.e. latch with release hidden on underside) to the entrance of the main floor serveries.
2. Orient all dietary staff assigned to the two serveries to ensure that the gates are are kept closed and latched or locked when the serveries are vacated by staff.

Option #2:

1. Re-train all dietary staff assigned to the two serveries to ensure that all heat generating appliances are not operable once the serveries are vacated by staff. This includes the steam table, microwave ovens, toasters, cook tops and dish warmers.
2. Re-train all dietary staff assigned to the two serveries to ensure that all dishes, cutlery, food and beverage items, cleaning and dishwash products located in the two serveries are kept locked or inaccessible to residents once vacated by staff.
3. The electrical outlets that serve any portable heat generating appliances such as toasters and microwaves are to be connected to the power termination keypad.
4. Keep a record of the staff who attended the re-training sessions, identify who completed the re-training, identify which policy and procedure was reviewed with staff regarding the issues noted above and the dates of the re-training.

Grounds

The licensee has failed to ensure that the home was a safe environment for its residents.

Rationale and Summary

The two neighborhoods serveries on the main floor were not equipped or designed with a physical barrier to the entrances of the serveries. Instead, staff were using snack and beverage carts to block the entrances. One of the Neighborhood serveries entrances were equipped with retractable belts that could be used, but these were ineffective at preventing resident entry. As a result, residents had access to heat generating appliances such as the range ovens, toaster, microwave oven, and dishwasher. Both serveries, when toured, did not have the electrical system locked out for the range ovens. The other appliances were not connected to a lock out system. In the Johnston servery, the steam table was left on, and a well with hot water in it was scalding hot. The steam table was equipped with a lockable door in which to lock out the control dials and on/off switch, but staff did not shut off the steam table after the lunchtime meal and lock out the dials.

The main ground floor area, near the office, a self serve station for visitors and residents included two hot water dispensing machines. Both the dining rooms included resident accessible hot water dispensing machines. The machines were designed to easily acquire hot water by pressing a button.

Both serveries included dishes and cutlery either out in the open or in cabinets and drawers that were unlocked. Refrigerators and snack carts with beverages and food items were also easily accessible to residents at the time of inspection.

The licensee received a complaint from a family member who observed three different residents touching items on the snack cart, and helping themselves to beverages, by drinking from the containers and replacing the beverages back on the cart. Residents were also observed going into the refrigerator and touching items, touching cleaned cutlery and dishes.

Staff were present during these observations and were noted to try and dissuade residents from the serveries but were physically assaulted and/or verbally attacked.

The lack of a physical barrier into the serveries may increase the risk to residents for burn injuries. The ease of access to snack and beverage carts, the refrigerator, cutlery and dishes in the serveries increases the risk of cross-contamination of disease-causing organisms from one resident to another.

Sources:

Interviews with the General Manager and Director of Dietary Services and observations of the serveries and main common area.

This order must be complied with by

November 8, 2024

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609 Kumpf Drive, Suite 105
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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.