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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
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Amended Public Report (A1)

Report Issue Date: November 8, 2022	
Inspection Number: 2022-1231-0001	
Inspection Type: Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: Erin Mills Lodge Nursing Home, Mississauga	
Inspector Who Amended April Chan (704759)	**Inspector Digital Signature** April W Chan Digitally signed by April W Chan Date: 2022.12.13 15:13:01 -05'00'

AMENDED INSPECTION REPORT SUMMARY

This public inspection report was amended to rescind a Written Notification: NC#003 was rescinded. The Critical Incident System inspection, 2022-1231-0001, was completed on October 20, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s):
October 12-14, 17-20, 2022.

The following intake(s) were inspected:

- Intake: #00002754 [Critical Incident (CI): 2736-000001-22] related to fracture of unknown cause.
- Intake: #00003462 (CI: 2736-000002-22) was related to alleged staff to resident abuse.
- Intake: #00005955 (CI: 2736-000005-22) was related to alleged staff to resident abuse.
- Intake: #00006093 (CI: 2736-000007-22) was related to alleged staff to resident abuse.

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- Intake: #00006468 (CI: 2736-000004-22) was related to alleged staff to resident abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

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)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that additional requirements under the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022" (IPAC Standard) were followed.

Specifically, Additional Requirement 10.1 under the IPAC Standard states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

On October 12, 2022, Inspectors #740849, #704759 and #741073 located ABHR of various alcohol percentages including 62% at the entrance of a dining room. Staff were observed using these ABHR to assist residents in performing hand hygiene prior to lunch service. The IPAC Lead indicated that ABHR of less than 70% would not effectively kill viruses.

After the IPAC Lead was notified of the observations, the IPAC Lead stated that the home removed all the 62% ABHR on October 13, 2022. ABHR of less than 70% were no longer observed during the remainder of the inspection. There was low risk to residents as there were other ABHR found in the dining room with at least 70% alcohol.

Date Remedy Implemented: October 13, 2022

Sources: interview with the IPAC Lead, and observations by Inspector #740849, #704759 and #741073.

[740849]

The licensee has failed to ensure that additional requirements under the IPAC Standard were followed.

Specifically, Additional Requirement 6.1 under the IPAC Standard states that the licensee shall make Personal Protective Equipment (PPE) available and accessible to staff and residents.

On October 12, 2022, Inspectors #740849, #704759 and #741073 found gloves that were loosely stored in a wall caddy of a resident's room that required contact precautions. No gloves in their original packaging were found in the wall caddy. The posted contact precaution signage indicated that gloves were required before entering the room.

The IPAC Lead stated that gloves should have been stocked in their original packaging. The IPAC Lead further stated that gloves found outside of their original packaging could be contaminated. There was low risk to residents as the IPAC Lead clarified that team members would not use gloves outside of the box. Team members would use gloves from a new box that were restocked in the wall caddy.

After the IPAC Lead was notified of the observations, all wall caddies were restocked with gloves in their original packaging on October 13, 2022.

Date Remedy Implemented: October 13, 2022

Sources: interview with the IPAC Lead, and observations from Inspector #740849, #704759 and #741073.

[740849]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee has failed to ensure that incidents of suspected abuse to three residents were immediately reported to the Director.

In accordance with s. 24 (1) 2 of the Long-Term Care Homes Act, 2007. Pursuant to s. 152 (2) the licensee is vicariously liable for a staff member failing to comply with s. 24 (1).

Rationale and Summary
A Critical Incident System (CIS) report was received by the Ministry of Long-Term Care (MLTC) on a specific date, for suspected abuse of three residents by a Personal Support Worker (PSW).

On the specified date, another PSW witnessed suspected abuse during care by the PSW to three residents but had not immediately reported the abuse to the home until four days later. The incidents of suspected abuse were related to rough handling during care.

The PSW acknowledged that they should have reported the incidents of suspected abuse to the home the day it occurred and not four days after; they were confused about whether the incidents constituted abuse. The home reported the incidents of suspected abuse to the Director one day after receipt of the staff member's report. The Director of Nursing Care (DOC) acknowledged that the suspected abuse should have been reported immediately to the Director. There was low impact or risk of harm to the residents when reporting requirements were not met.

Sources: The home's investigation notes, CIS reports and interviews with a PSW and DOC.

WRITTEN NOTIFICATION: Actions by inspector if non-compliance found

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 152 (2)

This non-compliance under LTCHA s. 152 (2) was rescinded.

WRITTEN NOTIFICATION: Police notification

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 98

The licensee has failed to ensure that the police were notified immediately after the home was informed of suspected abuse of three residents.

Rationale and Summary
As mentioned above, on a specified date, incidents of suspected abuse occurred during care by a PSW to three residents. The home was informed of the incident on a specific date and notified local police services four days later.

The DOC stated the home was conducting their investigation but acknowledged that the police should have been notified of suspected abuse the same day the home was notified. There was low impact and risk of harm to the residents when police notification requirements were not met.

Sources: The home's investigation notes, CIS reports, and interviews with a PSW and DOC.

[741073]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 3 (1) 1.

The licensee has failed to ensure that resident's #001 and #004 were treated with courtesy and respect in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Rationale and Summary
On a specific date, a PSW witnessed suspected abuse during care by another PSW to residents #001 and #004. The PSW stated that during a bed bath, resident #001 was moving in bed as they had physical and cognitive impairments and witnessed the other PSW's rough handling of the resident. After changing resident #004's clothes, resident #004 had verbal expressions due to their cognitive impairment and personal expression, and the PSW verbally responded to the resident in a negative way.

The PSW who witnessed the incidents and the DOC acknowledged that these incidents of rough handling by the other PSW failed to respect the resident's rights to be treated with courtesy and respect. There was moderate risk of harm to the residents' wellbeing when the residents were not treated with respect.

Sources: The home's investigation notes, CIS reports, and interviews with a PSW and DOC.

[741073]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that routine practices of hand hygiene of the IPAC program were followed by a staff member.

The licensee failed to ensure that routine practices including hand hygiene were followed by a staff member in accordance with the IPAC Standard for Long Term Care Homes April 2022.

Specifically, hand hygiene after resident and resident environment contact was not performed as was required by Additional Requirement 9.1 (b) under the IPAC Standard.

Rationale and Summary
On October 12, 2022, a PSW assisted a resident inside their room and was observed exiting the resident's room and into the dining room area without performing hand hygiene.

The home's policy on hand hygiene states four moments when hand hygiene should be performed. Staff members were expected to perform hand hygiene after contact with a resident or their environment, and when leaving a resident's environment. The PSW and the IPAC Lead agreed that hand hygiene should be performed after leaving the resident's environment.

Sources: the home's hand hygiene policy (Tab 06-13, inspector reviewed October 12, 2022), observations on October 12, 2022, interviews with a PSW and the IPAC Lead.

[704759]