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
Waterloo, ON, N2V 1K8
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Amended Public Report (A1)

Report Issue Date: December 9, 2022	
Inspection Number: 2022-1399-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Riverside Glen, Guelph	
Lead Inspector Nuzhat Uddin (532)	**Inspector Digital Signature** Nuzhat Uddin Digitally signed by Nuzhat Uddin Date: 2022.12.19 12:38:36 -05'00'

MODIFIED PUBLIC INSPECTOR REPORT SUMMARY

- The licensee inspection report has been revised to reflect the change of revoking a written notification of medication administration.
- The complaint inspection #2022-1399-0001 was completed on November 9, 2022.

INSPECTION SUMMARY

- The following intake(s) were inspected:
  The Inspection occurred on the following date(s):
  October 26- 31, November 1-4 and 7-9, 2022.

  The following intake(s) were inspected:
- Intake: #0009352-IL-06125-AH related to staff to resident alleged abuse.
- Intake: #00011537-IL-06504-CW related to medication administration.

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

Medication Management
Infection Prevention and Control

Pain Management
Reporting and Complaints
Resident Care and Support Services
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Minister's Directive

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (1)

The licensee has failed to ensure that the Minister's Directive related to the COVID-19 response measures for long-term care homes (LTCHs) was followed.

Rationale and Summary:
As per the Minister's Directive, licensees are required to ensure that appropriate masking requirements are followed by staff, students and volunteers. This includes wearing a medical mask for the entire duration of their shift indoors, regardless of the home's outbreak status.

During an observation of a group activity, a student wore their mask below their chin as they assisted multiple residents in performing physical exercises.

Not wearing a mask during group interactions placed residents and staff at potential risk for disease transmission.

Sources: Minister's Directive: COVID-19 response measures for LTCHs effective August 30, 2022, COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units Version 7 – June 27, 2022, and observations.

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WRITTEN NOTIFICATION: Duty to Protect

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

The Licensee has failed to ensure that a resident was protected from abuse by staff.

For the purpose of this Act and Regulation, "Verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

Rationale and Summary:
A Personal Care Assistant (PCA) reported that they witnessed verbal abuse towards a resident.

The resident remembered the incident and stated that the staff member's behavior was abusive.

The home not ensuring that the resident was protected from verbal abuse by a staff member placed the resident at potential risk of harm.

Sources : Abuse Policy, CIS, progress notes for a resident, interview with NC and PCAs and other staff.

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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that when staff had reasonable grounds to suspect that abuse or improper care of a resident had occurred, that they immediately reported the suspicion to the Director in accordance with s. 28 (1) 2 of the Long-Term Care Homes Act (LTCHA). Pursuant to s.154 (3), the licensee is vicariously liable for staff members failing to comply with subsection 28 (1).

Rationale and Summary:
A) A critical incident report documented an allegation that a staff member was rough and verbally abusive with residents.

A staff member indicated that the resident had been complaining of the same "rough treatment" from the staff member for a week prior; however, they did not believe the resident. They said they considered what the resident was telling them to be an allegation of abuse and knew that they were supposed to report it right away.

The alleged abuse was reported to the Director, approximately five days after the staff member was made aware.

B) A staff member reported that they witnessed verbal abuse towards a resident and reported the incident to a Neighborhood Coordinator (NC).

The NC denied that they were informed of the alleged abuse.

By not reporting the alleged incidents of abuse and improper care immediately to the Director, it may delay actions required to respond to the incidents, which placed residents at risk of harm.

Sources: Abuse Policy, CIS, progress notes for a residents, interview with NC and PCAs and other staff.

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WRITTEN NOTIFICATION: Infection Prevention and Control

NC #004 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 the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary:
According to O. Reg 246/22, s.102 (2)(b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC. The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 9.1, documented that the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum, routine practices shall include b) hand hygiene, including, but not limited to the four moments of hand hygiene: before initial resident/resident environment contact, before any aseptic procedure, after body fluid exposure risk, and after resident/resident environment contact. At minimum, additional precautions shall include e) Point-of-care signage indicating that enhanced IPAC control measures are in place; f) Additional PPE requirements including appropriate selection application, removal and disposal.

A) A Registered Practical Nurse (RPN) did not perform hand hygiene prior to or in-between a medication administration pass. The RPN picked up dirty plastic spoon from the floor, gave nasal spray and crushed medications without performing hand hygiene.

B) On October 31, 2022, an isolation cart was parked outside of a resident's room; however, there was no signage posted at the entrance to the resident's room or bed space, to indicate enhanced infection prevention and Control (IPAC) measures were in place. A Registered Nurse (RN) said that the resident had been in isolation for approximately one day, and the polymerase chain reaction (PCR) test was pending.

C) On October 31, 2022, an identified room had a droplet contact precaution sign posted on the door; however, the isolation cart outside the room was missing eye protection, and appropriate garbage bin for disposal of PPE. An RN confirmed that the resident had been having emesis for approximately one day.

When staff did not perform hand hygiene or follow the additional precautions of point-of-care signage and additional PPE requirements including appropriate selection and disposal, they may have increased the risk of transmission of infection to other residents, staff and visitors in the home.

Sources: COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units Version 7 – June 27, 2022, Hand Hygiene policy, and observations dated October 26, 31, and November 4, 2022, interviews with an RN and the IPAC lead.

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WRITTEN NOTIFICATION: Administration of dugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 140 (6)

The licensee has failed to ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident.

During a medication pass, a registered staff left oral medications on the table for multiple residents for self-administration. One of the medications included a controlled substance.

The registered staff member did not stay to observe the self-administration of medications for any of the identified residents. The registered staff member shared that they regularly leave the medications on the table for these residents.

The identified residents had no physician's order for self-administration.

Allowing residents to administer medications to themselves without being approved by the prescriber and not supervising the residents during a medication administration pass placed residents at moderate risk of harm.

Sources: Clinical records i.e., Medication administration record (eMAR), physician's order, plan of care, Administration of medication policy, Medication administration observations and interviews with the DNC and registered staff.

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WRITTEN NOTIFICATION: Continence care and bowel management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 56 (2)

The licensee has failed to ensure that a resident who was incontinent had 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 was implemented.

A complaint was received related to a resident's incontinence concerns and odour in the room.

The identified resident's plan of care related to bladder incontinence stated that the team member(s) were to assist and encourage the resident to use the washroom at scheduled times, and as needed.

A PCA said that the resident was not toileted due to their disability and there was no toileting plan. The resident used an assistive device during the day, however, at night, the assistive device not used.

A record review documented that the resident had a fall on an identified night related to being incontinent and attempting to get to the bathroom.

A staff member said that the resident never used an assistive device on nights and their bedding and clothing were changed couple of times in the week due to incontinence issues.

The resident did not have an individualized plan related to continence, as part of their plan of care, to promote and manage bowel and bladder continence that was based on an assessment.

Not providing an individualized continence plan, as part of the resident's plan of care, placed the resident at risk of discomfort, falls, and skin breakdown.

Sources: Record review, plan of care, incident summary, interview with a resident, PCAs and other staff.

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COMPLIANCE ORDER CO #001 Palliative Care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 61 (4) (a)

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

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

1) Ensure that a resident ‘s plan of care for palliation and comfort measures is updated to include specific directions related to repositioning and pain management interventions.

2) The home must ensure that the interventions for palliation and comfort measures are implemented by staff.

3) Conduct an audit of all palliative care residents at the Home to ensure that their comfort measures and quality of care improvements are implemented by staff.

4) Conduct an audit of the home's point of care (POC) and delivery system in relation to palliative care residents at the Home to ensure that all interventions i.e., comfort measures, and turning and repositioning are reflected in the POC.

5) Ensure that all audits are documented and include the dates and names of those that completed them as well as the actions taken by the home, in response to results.

Grounds
The licensee has failed to ensure that, based on the assessment of a resident’s palliative care needs, the palliative care options made available to the resident included, at a minimum quality of life improvements.

A) A resident was on palliative care measures. The resident had an order for comfort care related to

their diagnosis.

The home's Palliative/End of Life Care policy focused on maintaining and promoting comfort, dignity, and optimum quality of life for residents with palliative and/or end of life needs. It stated that the resident may be repositioned every one to two hours and care provided to reduce skin breakdown and relieve pressure areas.

The resident had multiple altered skin integrity issues.

On multiple occasions the resident was observed in an assistive device for an extended period of time.

A staff member said that they observed the resident in pain during care. They also observed the concerns related to skin integrity from not being repositioned. The staff member was concerned that the resident was not being turned or repositioned.

An RN stated that the expectation was that residents with altered skin integrity issues were repositioned; however, the two-hour repositioning was deleted from point of care (POC) due to a conversion in the system and staff were not able to document on the two-hour repositioning.

The DNC stated that for a resident to stay up for long periods of time was excessive, a steady state of comfort should be maintained, and regular monitoring should occur.

B) A resident ‘s plan of care related to pain stated that the resident was to receive regular scheduled analgesics for pain management, as needed analgesic for breakthrough pain, and the team member(s) were to use the Pain Assessment to assess their pain.

Clinical record review indicated that the resident had responsive behaviors.

An RN stated that the PCAs were supposed to notify the registered staff before providing care, so the analgesic could be provided to the resident.

Several staff reported that the resident had been in pain for a while and the resident had responsive behaviors during care. The staff members said they were using the stop and go method during care to give the resident some time to rest in between; the resident sometimes had responsive behaviors that would alert the Registered staff.

There was actual harm to the resident when their palliative care needs were not met related to repositioning, comfort measures and when their plan of care was not reflective of their pain

management needs.

Sources: Record review i.e. Plan of care, progress notes, behavior monitoring, and interventions report, observations, interview with the DNC, PCAs, and RN.

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This order must be complied with by January 31, 2022.

COMPLIANCE ORDER CO #002 Dealing with complaints

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 108 (1) 1.

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

1) Ensure that the home's Complaints policy and procedures are updated to include a process for dealing with verbal and written complaints concerning the care of a resident or operation of the home from all individuals, including staff members.

2) Ensure that all members of the leadership team are trained and educated on the updated policy.

3) Ensure that there is a record kept of the training including the name of the person who provided the training, the names of the person who attended the training, what was reviewed in the training, and date the training was conducted. The record must be maintained in the Home.

Grounds
The licensee has failed to 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 was dealt with as follows: 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.

The home’s Assistant General Manager (AGM) and Neighborhood Coordinator (NC) received written complaints from staff members for an identified period of time. These concerns were related to the care of residents and operation of the home.

The home's policy called Resident / Family Complaints stated that it was the policy of Schlegel Villages to be responsive to family and resident complaints expressed in an effort to improve, where practicable, the specific and general quality of all elements pertaining to resident life at the Village.

The policy did not state how the written or verbal complaints concerning the care of a resident or operation of the home would be dealt with when the complaints came from someone other than a resident or a family member i.e., staff, visitor, volunteer, or a student.

The AGM stated that there were no written policies or procedures on how to address staff complaints concerning the care of a resident or operation of the home. They stated that most complaints were dealt with verbally with the staff member who brought them forward. However, when going through the complaints with the AGM it was noted that several concerns were never addressed or dealt with, and most were forwarded to the NC.

There was a high risk of harm to residents when there was no policy and/or procedure developed or implemented to address the written or verbal complaints made to the licensee by staff, volunteers, or other disciplines concerning the care of a resident or operation of the home.

Sources: Written complaints, Home's policy called Resident / Family Complaints, interview with AGM, DNC, NC, PCA and other staff.

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This order must be complied with by January 31, 2022

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.