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: February 9, 2023	
Inspection Number: 2023-1399-0003	
Inspection Type: Complaint and Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Riverside Glen, Guelph	
Lead Inspector Kristen Owen (741123)	**Inspector Digital Signature** Kristen A Owen Digitally signed by Kristen A Owen Date: 2023.02.13 14:57:31 -05'00'
Additional Inspector(s) Kaitlyn Puklicz (000685) Janis Shkilnyk (706119) Alicia Campbell (741126)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 19-20, 23-27, 2023

The following intake(s) were inspected:

- Intake: #00002039 related to alleged improper care of a resident.
- Intake: #00003836 related to the prevention of abuse and neglect and responsive behaviours of residents.
- Intake: #00010930 and intake: #00011933 related to emergency plans involving missing residents.
- Intake: #00018229 related to a complaint regarding a resident's care.

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

Reporting and Complaints
Resident Care and Support Services
Infection Prevention and Control
Skin and Wound Prevention and Management
Safe and Secure Home
Medication Management
Housekeeping, Laundry and Maintenance Services

Continence Care
Responsive Behaviours
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. 19

The licensee has failed to ensure the window in a resident's room, that opened to the outdoors and was accessible to residents, had a screen in place.

Rationale and Summary
On an identified date, a resident eloped from the home through their bedroom window, by breaking the window stops and removing the window screen.

During the inspection, the window in the resident's room was observed without having a screen in place. The Neighbourhood Coordinator confirmed the screen was not in place and notified maintenance immediately. Maintenance installed the window screen later that day.

Having no window screen in place posed a risk to residents safety as this window opened to the outdoors and was accessible to residents.

Sources: Inspector #741123's observations during the inspection, and interviews with staff.

Date Remedy Implemented: January 26, 2023

[741123]

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 resident #006 was protected from abuse by resident #005.

"Physical abuse" is defined as the use of physical force by a resident that causes physical injury to another resident. O. Reg. 246/22, s. 2 (1).

Rationale and Summary
On an identified date, resident #005 was observed to push resident #006 causing them to fall and sustain an injury. Resident #006 was transferred to the hospital for assessment.

An Assistant Director of Nursing Care (ADNC) stated that as a result of being pushed by resident #005, resident #006 sustained an injury.

This incident of physical abuse caused actual harm to resident #006 as they sustained physical injuries when the incident occurred.

Sources: Review of resident #005 and resident #006's clinical records, the Critical Incident report, and interviews with staff.

[706119]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

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 the resident's change in condition.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC), related to a written complaint received by the home from the resident's SDM. The SDM had not been informed of a change of condition for the resident.

The home's documentation indicated the resident experienced a change in their health status. The SDM was not notified. An ADNC confirmed that the SDM was not notified related to a change of condition for the resident and should have been.

When the home did not notify the resident's SDM of the resident's change of condition it may have delayed the SDM's participation in the development of the plan of care.

Sources: Review of the resident's clinical records, the CI report, and interviews with staff.

[706119]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure a skin assessment was completed by a member of the registered nursing staff on a resident, using a clinically appropriate assessment instrument specifically designed for skin and wounds, when documentation on an identified date, indicated the resident had sustained a skin impairment to a specified area.

Rationale and Summary
The home's documentation showed that the resident moved while receiving care and sustained a skin impairment to a specified area.

Several days later, the resident's skin impairment was assessed and measured. A Registered Practical Nurse (RPN) stated that after a resident received a skin impairment, an initial skin assessment should be completed.

Director of Care (DOC) #100 stated that the resident should have had a skin and wound assessment for their skin impairment at the time of documentation.

The home's failure to complete a skin and wound assessment for the resident at the time the skin impairment was identified could have impacted treatment and thus the healing of the skin condition.

Sources: The resident's clinical records and interviews with staff.

[706119]

WRITTEN NOTIFICATION: General Requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions were documented, when responses were not documented for a resident's care provided.

Rationale and Summary
A complaint to the MLTC alleged a resident was not being assisted with a specified activity of daily living (ADL). A PSW and an RPN stated that residents should be assisted with the specified ADL in the morning and in the evening.

According to the home's documentation, the specified ADL was only documented on once on the following days: one identified day in August 2022, four identified days in September 2022, two identified days in October 2022, and three identified days in December 2022.

A PSW stated the specified ADL should be documented in Point of Care (POC) and the responses include yes, no, not applicable or resident refused. An RPN stated the direct care staff assist residents with the specified ADL and it is required to be documented. DOC #100 said the expectation for documentation related to the specified ADL, is expected to be captured shortly after the care is provided, and confirmed that since it is required in the morning and in the evening, it should be documented twice daily, typically by two separate staff.

By not documenting if the resident had the care provided, staff would not have been alerted if the resident's ADL was completed or missed, posing a risk to the resident having poor hygiene.

Sources: Follow up question reports (ADL's) for August 2022, September 2022, October 2022, and December 2022, and interviews with staff.

[741123]