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: 2023-1399-0004	
Inspection Type: 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: 2023.02.14 10:10:30 -05'00'
Additional Inspector(s) Alicia Campbell (741126) Janis Shkilnyk (706119) Kaitlyn Puklicz (000685)	

INSPECTION SUMMARY

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

The following intake(s) were inspected:

- Intake: #00005636 related to the prevention of abuse and neglect of a resident.

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The licensee has failed to ensure a resident was protected from abuse by Personal Support Worker

(PSW) #128.

"Physical abuse" is defined as the use of physical force by anyone other than a resident that causes injury or pain. O. Reg. 79/10, s. 2 (1).

Physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances. O. Reg. 79/10, s. 2 (2).

Rationale and Summary
On an identified date in 2021, PSW #127 and PSW #128 reported to Registered Practical Nurse (RPN) #125 that during the resident's care, the resident was resisting care and staff held the resident's arms to stop them. This resulted in skin impairments to specified areas of the resident.

The resident alleged that during their care on the identified day, PSW #127 and PSW #128 held them down so they could not move, and proceeded with their care, despite the resident's protests that they did not want to receive the care. The resident reported that during the care, they were telling staff they did not want the care and pushed their arms out to stop the staff.

RPN #125 said it would not be normal to hold a resident's limbs down during care and if a resident is refusing care, staff should stop providing the care to ensure resident safety.

Skin assessments were completed for the resident, all of which identified new skin impairments on the resident to specified areas. The physician examined the resident and documented concerns of nerve damage and a possible dislocated body part. The physician recommended the resident be transferred to the hospital for x-rays.

The Director of Nursing Care (DNC) referred to the resident's skin impairments as significant injuries, and indicated they were likely a result of the incident during their care on the identified day. The DNC stated that it appeared excessive force might have been used in this circumstance.

Following this incident, PSW #128's employment was terminated for engaging in inappropriate conduct violating the Resident Bill of Rights.

The resident sustained multiple injuries and experienced pain as a result of this incident.

Sources: The resident's clinical health records, the home's internal investigation file, the home's

Prevention of Abuse and Neglect Policy, tab: 04-06, manual: Human Resources, section: Code of Conduct, subject: Prevention of Abuse and Neglect LTC, and interviews with staff.

[741126]