Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Original Public Report

Report Issue Date: March 28, 2023	
Inspection Number: 2023-1399-0005	
Inspection Type: Follow up Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Riverside Glen, Guelph	
Lead Inspector Janis Shkilnyk (706119)	**Inspector Digital Signature** Janis M Shkilnyk Digitally signed by Janis M Shkilnyk Date: 2023.03.29 13:19:04 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 14, 15, 16, 22, 23, 24, 2023

The following intake(s) were inspected:

- Intake: #00016545, fall of a resident with injury
- Intake: #00005210, improper/neglect care from unknown staff that resulted in resident fall with injury.
- Intake: #00015586 - Follow-up #: 001 - O.Reg. 246/22 - s. 61 (4) (a)
- Intake: #00015587 - Follow-up #: 002 - O.Reg. 246/22 - s. 108 (1) 1

The following intake(s) were completed in this inspection:

intake # 00001263, and intake #00015482, fall of a resident with injury.

Previously Issued Compliance Order(s)

Order #001 from Inspection #2022_1399_0001 related to O.Reg. 246/22 - s. 61 (4) (a), was complied.
Order #002 from Inspection #2022_1399_0001 related to O.Reg. 246/22 - s. 108 (1) 1, was complied.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Palliative Care
Reporting and Complaints
Pain Management
Falls Prevention and Management

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 failed to ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% alcohol-based hand rub (ABHR).
During observations on March 14, 2023, pump bottles of ABHR were observed at the front entrance of the home, on the screeners desk and on tables staff and visitors sat at waiting for rapid antigen testing results. The alcohol-based percentage was identified on the label of the bottle as 60% alcohol.
The Infection Prevention and Control Lead removed all pump bottles containing 60% alcohol and replaced these with alcohol-based hand rub, labeled 70-90% alcohol. There was no impact and low risk to the residents for infection as 70-90% alcohol-based hand rub was available throughout the resident areas.

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Date Remedy Implemented: March 14, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a resident's Personal Assistance Service Device (PASD) was utilized when staff did not apply the device when the resident was in their wheelchair.

Rationale and Summary

A resident's care plan documented that the resident utilized a PASD tabletop. An assessment documented the resident was to have a PASD on at all times when up in their wheelchair.

The resident fell from their wheelchair on to the floor in their room. The resident sustained an injury and required hospitalization. The resident did not have a tabletop tray in place on their wheelchair at the time of the fall.

The Assistant General Manager (AGM) stated that the resident's care plan was not followed when staff did not apply the PASD as directed to by the care plan and should have been.

A staff member stated they were aware that the resident required a PASD for positioning and did not apply the PASD after assisting the resident to their wheelchair and should have.

Failure to follow the resident’s plan of care with respect to utilizing a PASD for the resident led to actual harm to the resident.

Sources:

Critical Incident, resident’s care plan, progress notes, interviews with staff members.

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