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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: July 5, 2023

Inspection Number: 2023-1399-0006

Inspection Type:
Complaint
Critical Incident System

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Riverside Glen, Guelph

Lead Inspector	**Inspector Digital Signature**
Alicia Campbell (741126)	Alicia Campbell Digitally signed by Alicia Campbell Date: 2023.07.06 10:35:30 -04'00'

Additional Inspector(s)
April Racpan (218)
Helene Desabrais (615)
Josee Snelgrove (674)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 26-30, 2023

The following intake(s) were inspected:

- Intake #00022030 - related to staff to resident abuse
- Intake #00085861 - related to resident to resident abuse
- Intake #00085967 - related to staff to resident neglect and improper care.
- Intake #00086343 - complaint related to medication administration and neglect/improper care of a resident
- Intake #00087062 - unexpected death of a resident
- Intake #00087785 - complaint related to an unexpected death of a resident
- Intake #00088900 - related to injury to a resident of unknown cause
- Intake #00089907 - related to a fall of a resident resulting in injury

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

- Intake #00022339 - related to a fall of a resident resulting in injury
- Intake #00084671 - related to a fall of a resident resulting in injury

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.

The licensee has failed to ensure that a residents choice with regards to life saving measures was respected.

Rationale and Summary

A complaint was submitted to the Ministry of Long-Term Care regarding a resident receiving life saving measures against their wishes. The resident understood and appreciated the risks involved with life saving measures and had decided it was not an intervention that the resident had wanted. The form that specified the residents wishes was to be kept in the front page of their chart.

When paramedics arrived at the home in response to an incident involving the resident, the Registered Nurse (RN) was unable to locate the form that specified the residents wishes. The paramedics initiated life saving measures and continued to perform them until a new form was created and provided to them.

Not having the residents form accessible resulted in the resident receiving life saving measures against their wishes.

Sources: resident's progress notes, DNR order forms, POET Assessment; Interviews with PSW #123, RPN #122, RN #121 and Administrator #100; Advance Care Planning/Expressing Wishes Policy; Homes Investigation Notes; Conversation with Complainant.

[741126]

WRITTEN NOTIFICATION: Altercations and Other Interactions Between Residents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between a resident and other residents, including, identifying factors, based on an interdisciplinary assessment.

Rational and Summary

A resident demonstrated physical responsive behaviours towards another resident, which resulted in pain.

Despite the resident having a history of previous incidents where they demonstrated physical responsive behaviours towards other residents, identifying factors and an interdisciplinary behavioural assessment were not completed until after this incident.

The Assistant Director of Nursing-Personal Expression Resource Team (ADON-PERT) Lead stated that the resident should have been assessed and interventions put in place when they previously demonstrated responsive behaviours.

The home's failure to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions caused harm to another resident.

Sources: Critical Incident Report, resident's clinical records and plan of care, home's Personal Expression Program (no date), interviews with RPN #102, #103, and the ADON-PERT Lead.

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WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (3) (b) (ii)

The licensee has failed to ensure that a Personal Care Assistant (PCA) received training about medication orders and order types prior to administering medications to residents.

In accordance with FLTCA s. 196 (3), the Training Guideline for Personal Support Workers Administering Drugs in Long-Term Care, dated May 1, 2023, is required to be complied with.

Specifically, the licensee did not comply with the component that personal support workers need to be trained before they can be eligible for administering drugs as required by the guideline.

Rationale and Summary

A complaint was submitted to the Ministry of Long Term Care reporting that Personal Care Assistant's (PCA) were asked to administer oral medications to residents.

A Registered Practical Nurse (RPN) and A PCA both stated that PCAs were assisting with the administration of oral medications to residents. An Assistant Director of Nursing (ADON) said only registered staff were to administer oral medications to residents. They also indicated that the licensee has not developed a program or policy for the training of PCAs for medication administration at this time.

The residents were placed at risk of harm when PCAs were administering medications without the required training and knowledge of the medication administration process.

Sources: Complaint, Home's policy Administration of Medications, interviews with RPN's #102, #106, #107, PCAs #105 and 108, and ADON #101.

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