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 22, 2024	
Inspection Number: 2024-1399-0003	
Inspection Type: Complaint Critical Incident	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Riverside Glen, Guelph	
Lead Inspector Craig Michie (000690)	**Inspector Digital Signature** Craig R Michie Digitally signed by Craig R Michie Date: 2024.07.22 11:14:00 -04'00'
Additional Inspector(s) JanetM Evans (659) Brittany Nielsen (705769) Sarah Doepel (000858) Bhavin Mistry (000863)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 28-31, 2024, and June 3-4, 7, 10, 2024.
The following intake(s) were inspected:

- Intake: #00110336, related to Infection Prevention and Control.
- Intake: #00113368, related to Prevention of Abuse and Neglect, and Responsive Behaviours.
- Intake: #00114517, related to Prevention of Abuse and Neglect, and Responsive Behaviours.
- Intake: #00113215, a complaint related to Falls Prevention and Management, Pain Management and Resident Care and Support Services.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Pain management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

Non-compliance with O. Reg. 246/22, s. 57 (1) (4).

The licensee has failed to comply with their pain management program for resident #005.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee is required to ensure that monitoring of residents' responses to, and the effectiveness of, the pain management strategies, is complied with.

Rationale and Summary

A resident experienced an unwitnessed fall which resulted in a fractured hip.

The home's Administration of Medications Policy stated that when administering a PRN medication, it should be communicated with the team to ensure follow up as to its effectiveness and that this is documented.

A) A residents progress notes stated that a pain assessment was completed pre-analgesic when the resident was given a PRN medication. At that time the resident's pain level was at a five out of 10.

There was no assessment completed to determine the effectiveness of this medication.

The home's failure to assess the effectiveness of the PRN medication may have led to the resident being in pain for an extended period of time.

Sources
A resident's clinical records, Pain Management Program dated September 15, 2023, Administration of Medications Policy dated August 2, 2023, Interview with staff. [000690]

B) Staff documented, pain assessment done, in the residents progress notes. However, the findings of the pain assessment were not indicated in the progress note.

The home's failure to document the resident's responses to and the effectiveness of pain management strategies at the time of the assessment by staff may have

resulted in insufficient pain management.

Sources

A resident's clinical records, Pain Management Program dated September 15, 2023, Interview with staff.
[000690]

WRITTEN NOTIFICATION: Responsive Behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

NC with O. Reg 246/22, s. 58 (4) (b).

The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies were implemented to respond to the behaviours where possible.

Rationale and Summary

A resident was known to push, hit and scratch others when they entered their personal space. The plan of care directed staff to ensure all needs were met, ensure the safety of the resident and others around them, and to redirect the resident as needed.

A resident was in another residents personal space and as a result of being in the other resident's personal space was pushed, which caused the resident to fall and experience an injury. Staff did observe the resident going into the other resident's personal space and saw the other resident shake their finger at the resident who entered their personal space. They did not redirect either resident or intervene at that time.

The DOC indicated that staff should have intervened and separated the residents when they observed the resident in the other resident's personal space.

By failing to implement existing interventions set out in the resident's plan of care, a resident was pushed and physically injured.

Sources:
A resident's Care Plan, Progress notes, Interview's with Staff.
[000858]

COMPLIANCE ORDER CO #001 Duty to protect

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

- Ensure a PSW receives training on responsive behaviour management, if not already completed after the incident involving two residents.
- Ensure a PSW reviews the plan of care for two residents related to personal expressions and behaviour management and interventions to be implemented.
- Document the training on responsive behaviour management and the review of two resident's plan of care outlined above, including the date and the person(s) who provided this. A record of the training and review must be kept in the home.
- Review and revise as needed, a resident's plan of care to ensure there are strategies in place to address their responsive behaviors.
- Complete an audit to evaluate the effectiveness of the responsive behaviour interventions for three residents. The audit should identify the residents and include, but not limited to, the dates of when the audits were completed, the person who conducted the audits, the results of the audit and actions taken. A record of the audit must be kept in the home.

Grounds

The licensee has failed to ensure that residents are protected from abuse from other residents.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A) Rationale and Summary

A resident approached another resident and a verbal exchange occurred. The resident who was approached then grabbed the other resident's arm causing an injury which resulted in them falling. The resident was known to exhibit responsive behaviours.

By failing to protect the resident from abuse, they were physically injured.

Sources:
A resident's progress notes, skin & wound evaluation, and interviews with staff. [000863]

B) Rationale and Summary

A resident had a history of responsive behaviours. Their plan of care directed staff to intervene if others were in their personal space or showing signs of agitation.

A resident approached another resident in the lounge and entered their personal space. The resident that was approached slapped the other resident in the face.

On another date, the same two residents were in the main lounge. The resident picked up the shoe of the other resident. Staff saw the other resident become agitated and shake their finger at the resident but did not intervene. The resident who picked up the other residents shoe was then pushed by the other resident causing them to fall and sustain a hip fracture.

By failing to protect the resident from abuse, they had a significant change in health status, requiring extensive assistance with activities of daily living and were wheelchair bound.

Sources:
The resident's progress notes, the two resident's care plans, and interviews with staff.
[000858]

This order must be complied with by July 26, 2024

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

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.