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

Public Report

Report Issue Date: December 19, 2024
Inspection Number: 2024-1399-0006
Inspection Type: Complaint Critical Incident
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Riverside Glen, Guelph

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 3-6, 9-10, and 12, 2024

The following intake(s) were inspected:

- Intake: #00129868 related to fall prevention and management.
- Intake: #00130123 related to allegations of neglect toward a resident.
- Intake: #00131298 related to allegations of neglect toward a resident.
- Intake: #00130696 related to allegations of neglect toward multiple residents.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure that a resident was protected from neglect.

Section 7 of the O. Reg. 246/22 defines "neglect" as the failure to provide a resident with treatment, care, services or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes health, safety, or well-being of one or more residents.

Rationale and Summary
On a specific day, a resident was found in worsened health condition from their baseline and was sent to hospital.

A staff member stated that during their shift, they did not perform adequate safety checks or repositioning of the resident as directed in the home's policy.

By failing to protect the resident from neglect, the resident was placed at increased risk of harm and negative health outcomes at the time of the incident.

Sources: Incident report, resident's clinical records, investigation notes, Night Time Safety Checks policy, and interviews with multiple staff.

WRITTEN NOTIFICATION: Skin and wound

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 3.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

The licensee failed to comply with their skin and wound care program, specifically related to documentation of repositioning for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to provide for strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, which must be complied with.

Rationale and Summary
On a specific day, two PSWs documented that they repositioned a resident at specific times.

One PSW stated they did not actually reposition the resident at the time they

documented.

The AGM stated the second PSW did not reposition the resident as documented, and that it would not be appropriate for staff to document a task as completed when it was not done.

By failing to accurately document, the resident's health record did not reflect when the appropriate interventions were completed.

Sources: Resident care plan, documentation survey, home's investigation notes, Skin and Wound Care program, Repositioning of Residents policy, interviews with multiple staff.

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