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: February 21, 2025

Inspection Number: 2025-1399-0001

Inspection Type:
Critical Incident
Follow up

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): January 28-31, 2025 and February 5-7, 11-14, 19 2025. The inspection occurred offsite on the following date(s): February 4, 13, 20, 2025

The following intake(s) were inspected:

- Intake: #00131977 - Follow-up #: 1 - O. Reg. 246/22 - s. 102 (2) (b)
- Intake: #00135233/2915-000050-24 - Enteric Outbreak Facility wide declared on 22 Dec-27 Jan 2025.
- Intake: #00135803/2915-000053-24 - Alleged verbal abuse of resident by staff.
- Intake: #00135800/2915-000052-24 - Alleged verbal abuse of resident by staff.
- Intake: #00136244/2915-000002-25 - Unwitnessed fall of resident resulting in an injury.
- Intake: #00136833/2915-000003-25 - Resident to resident physical abuse resulting in injury.
- Intake: #00136900/2915-000004-25 - Resident to resident physical abuse, resulting in injury.

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

- Intake: #00134456/2915-000049-24 - Unwitnessed fall of resident resulting in injury
- Intake: #00135556/2915-000051-24 - Unwitnessed fall of resident resulting in injury.
- Intake: #00137091/2915-000005-25 - Unwitnessed fall of resident resulting in injury.
- Intake: #00138409/2915-000008-25 - Unwitnessed fall of resident resulting in injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1399-0005 related to O. Reg. 246/22, s. 102 (2) (b)

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

Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure when a suspected incident of abuse of three residents was observed it was immediately reported to the Director.

A) In December 2024 it was alleged that a Personal Support Worker (PSW) was verbally inappropriate with a resident and was forceful during care. The incident was not reported to the Director until four days later.

Sources: Complaint email, home's investigation file, and interviews with staff.

B) In December 2024 a PSW reported witnessing verbal abuse of a resident by another PSW. The incident was not reported to the Director until four days later.

Sources: Critical incident #2915-000053-24, complaint email, home's investigation file, and interviews with complainant.

C) In March 2024 a resident entered another resident's room and an incident occurred resulting in pain to the co-resident. This incident was not reported to the Director.

Sources: Incident report, progress notes, and interviews with Assistant General Manager (AGM),

Director of Care (DOC), and staff.

WRITTEN NOTIFICATION: Pain Management

NC #002 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.

In accordance with O. Reg 246/22, s. 11 (1) b, the licensee is required to ensure that the written policies developed for the pain management program are complied with. Specifically, the home's pain management program directed staff to review, evaluate, and document resident outcomes to pain management.

In January 2025 a resident was assessed for pain. They were assessed as being a 4 on the pain scale, and a PRN was administered. The resident was assessed again over seven hours later. Their pain was 4 on the pain scale and a PRN was administered.

The Director of Nursing Care (DNOC) stated that this amount of time between assessments is not appropriate, and the risk to the resident is increased pain, not addressing the resident's pain at the source, and increased and prolonged pain and discomfort for the resident.

Sources: Interview with DNOC, pain assessments, and Pain Management Program policy.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented. Specifically, the licensee has failed to ensure that, in accordance with the IPAC Standard, revised September 2023, section 5.6, the high-touch surfaces are cleaned and disinfected, daily.

The Inspector observed that a housekeeper did not clean the following high-touch surface within a resident room: bedrails. The housekeeper stated that bedrails are cleaned once monthly during the room's "deep clean".

Sources: Observation on of cleaning and interview with a housekeeper.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

In December 2024 a complaint email was forwarded to the home and was received three days later by a neighbourhood coordinator.

A response was issued to the complainant 11 days later. The response did not include when they could anticipate a resolution.

Sources: CIS 2915-000052-24: LTCH C/R 2024, interview with AGM.

COMPLIANCE ORDER CO #001 Duty to protect

NC #006 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:

1. Review and revise the home's Personal Expression Resource Team (PERT) program as needed to:

A) Direct staff as to when they should make a referral related to personal expressions and to whom the referral should be made.

B) Ensure all PERT referrals are made electronically, for tracking purposes.

C) Direct staff as to which assessment tools and reassessment tools are to be used to assess a resident who is demonstrating personal expressions, and when each of these tools are to be completed and by whom.

2. All registered staff and any other staff involved in PERT processes will be educated on the above processes. The education will be documented including the name of the person providing the education, the name of staff attending the education, the time and date of the education, the content of the education. The documentation will be retained onsite.

Grounds

The licensee has failed to protect a resident from physical abuse by another resident.

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

In March 2024 a resident wandered into their co-resident's room and an incident occurred resulting in pain to the co-resident.

There were two other incidents of physical aggression between the two residents which occurred in 2024, and no injuries were sustained.

In January 2025 the same resident wandered into their co-resident's room and another incident occurred, resulting in an injury to the co-resident.

In January 2025 a second incident occurred where the resident wandered into the co-resident's room, and pain and injuries occurred to the co-resident.

A PSW said if the co-resident had not yelled at the first resident when they entered their personal space, then the resident would not have struck them.

The co-resident said they thought they were being targeted by the other resident. In addition, they said they were living next to a dangerous person.

The home's policy for personal expressions directs staff to consider completing an observational tool or assessment of the resident but it is not a requirement. Despite the number of altercations between the two residents, there were no behavioural assessment or reassessment of the resident completed prior to January 11, 2025, to determine root cause of the expressions and potential alternate interventions that could be trialed.

The home's policy related to resident to resident abuse indicates care plan interventions would be monitored by the neighbourhood team for effectiveness but does not provide direction as to what to do if the interventions are ineffective. In addition, the policy indicates staff should consider referrals to BSO (Behavioural Support Ontario) or PERT, however no referral to these

teams were made.

Sources: Incident reports, progress notes, and interviews with the co-resident and a PSW.

This order must be complied with by: March 21, 2025.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CH: WN issued to FLTCA in inspections: #2024-1399-0006 issued on December 19 2024, #2023-1399-0007 issued on November 27, 2023, #2023-1399-0003 issued on February 9, 2023 and #2022-1399-0001 issued on December 2, 2022.

CO issued to FLTCA s. 24 (1) in inspection 2024-1399-0003 on July 5, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this

requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.