Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 5, 2022	2021_937759_0008	015740-21	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

The Village of Erin Meadows
2930 Erin Centre Boulevard Mississauga ON L5M 7M4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

APRIL CHAN (704759)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 9, 10, and 13-16, 2021.

Log #015740-21 related to an allegation of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Administrator, Acting Director of Care (DOC), Infection Prevention and Control (IPAC) lead, Personal Expressions Resource Team (PERT) lead, Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff and residents.

During the course of the inspection, the inspector conducted observations of staff and resident interactions and the provision of care, reviewed resident health records, and relevant policies and procedures.

Inspector Praveena Sittampalam (#699) was present for this inspection.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written approaches to care set out in a resident's plan of care included the identification of behavioural triggers that may result in responsive behaviours.

A critical incident report was received for two residents regarding alleged resident to resident physical abuse.

On a specific date, there was an incident where two residents were seen fighting with each other on the floor. A resident sustained multiple injuries and was transferred to hospital and returned to the home the next day.

The resident had cognitive impairments, and a history of responsive behaviours including physical aggression towards staff. They also had a previous and a potential altercation with another resident. Behaviours included wandering that was easily altered. Mood was not easily predictable. Interventions were implemented for their wandering. Staff identified a potential social trigger for their responsive behaviours.

The resident's written plan of care did not include the identification of these potential behavioural triggers. No new revised written approaches to care related to responsive behaviours for the resident was implemented until after the above-mentioned incident.

Sources: Critical Incident System report, the home's investigative records, progress

notes, clinical records and care plan for the resident, interviews with PERT lead, and other staff. [s. 53. (1) 1.]

2. The licensee has failed to ensure that the written approaches to care set out in a resident's plan of care included the reassessment and identification of behavioural triggers that may result in responsive behaviours.

On a specific date, there was an incident where two residents were seen fighting with each other on the floor. A resident sustained multiple injuries and was transferred to hospital and returned to the home the next day.

The resident had cognitive impairments and had a history of responsive behaviours including physical and verbal aggression towards staff. They had a previous altercation and a potential altercation with another resident. The resident exhibited altered mood. Identified potential behavioural triggers included specific activities, and when co-residents entered their personal space. Behaviours were not easily altered. Potential triggers that were identified by staff was not included in the care plan until after the above-mentioned incident were the two residents were seen fighting on the floor.

Approximately a month prior to the incident, the resident had a potential altercation with another resident. Staff intervened and protected the other resident from the resident who was exhibiting physical aggression. PERT lead stated that the resident should have been reassessed, but the PERT was not informed, thus the resident was not reassessed. Approaches to care related to the reassessment and identification of potential behaviour triggers resulting in responsive behaviours was not identified in the written plan of care for the resident prior to the above-mentioned incident.

Sources: Critical Incident System report, the home's investigative records, progress notes, clinical records and care plan for the resident, interviews with PERT lead, other staff. [s. 53. (1) 1.]

3. The licensee has failed to ensure that written approaches to care included identification of behavioural triggers what may result in responsive behaviours for a resident.

The resident had cognitive impairments and was identified for potential triggers that lead to verbal and physical responsive behaviours. The resident had a recent history of responsive behaviours towards staff or other residents on four occasions.

The resident was identified by a registered staff member as having potential environmental triggers. Review of progress notes and clinical records showed that potential social triggers included agitation towards other specific residents. Behaviours included wandering, yelling, and physically attempting to hit other staff and residents. The resident received a specific intervention for behaviours.

The resident had identified potential environmental and social triggers that may result in responsive behaviours, but that were not specified in the plan of care.

Sources: The resident's care plan, progress notes and clinical records, and interview with a staff member. [s. 53. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that written approaches to care include reassessment and identification of behavioural triggers that may result in responsive behaviours for three residents., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A) On a specific date, a resident was observed by inspector #704759 being assisted by a staff member with their meal in a dining area, while two other staff members were also eating in the same area physically distanced from the resident.

Residents were not expected to eat meals in the dining area at the same time while staff members were also having meals. Staff members were expected to have their meals after the residents were finished eating in the dining area. The home's expectation for staff members when they are having meals are to be physically distanced from each other.

B) During the inspection, a resident's door was observed by inspector #704759 with isolation precaution signage for both droplet and contact precautions. The direct care staff who provided morning care for the resident on isolation was not able to identify which isolation precaution the resident required, but nonetheless wore gown, mask, and gloves while providing care to the resident. Prior to providing care, direct care staff were expected to clarify the isolation status of a resident with the nursing team if unsure. The resident was to be on contact precautions per the nursing team. Registered nursing staff noted that the droplet precaution signage was incorrect for the resident and should have been removed at the end of an outbreak.

During the tour of the home, there were numerous droplet precaution signage seen that remained from prior outbreak usage. Five out of six home areas had incorrect signs posted on resident doors in amounts of eleven, ten, three, eight, and two. A registered staff member stated that the signs should have been removed but it was not done. The IPAC lead discussed that registered nursing staff on the home areas were responsible for removing signage for isolation precautions once an outbreak was declared over. Per the home's Managing a Respiratory Outbreak policy, the isolation precaution signage should be removed at the end of outbreak.

Sources: observations, the home's Managing a Respiratory Outbreak policy, interviews with IPAC lead and other staff. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 31st day of January, 2022

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.