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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: April 12, 2024	
Inspection Number: 2024-1366-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Erin Meadows, Mississauga	
Lead Inspector Tracey Delisle (741863)	**Inspector Digital Signature** Tracey DeLisle Digitally signed by Tracey DeLisle Date: 2024.04.30 10:40:12 -04'00'
Additional Inspector(s) Waseema Khan (741104) Indiana Dixon (000767)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 29, 2024, and March 1, 4 - 7, 8, 12, 19, 2024.

The following intake(s) were inspected in this critical incident (CI) inspection:

Intake: #00087295 – Related to Prevention of Abuse and Neglect - Improper / incompetent care.
Intake: #00103353, #00104998, #00106566, IL-21943-AH – Related to Infection, Prevention and Control Program - Outbreak Management.
Intake: #00109562 – Related to Falls Prevention and Management Program – Fall that resulted in injury.

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The following intake(s) were inspected in this complaint inspection:

Intake: #00108264 - Resident Care and Services – improper/incompetent care.

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

Intake: #00090587, #00100999, #00108031, #00109230 – Related to Falls Prevention and Management Program

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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) 1.

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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to comply with immediate reporting of Improper or incompetent treatment or care of a resident .

Rationale and Summary

A Critical Incident (CI) was submitted on a day in May, 2023, and the written complaint was submitted to the Home on a day in April, 2023.

During the interview, staff acknowledged that this CI was reported late and confirmed that staff failed to follow the process for reporting certain matters to the Director immediately.

The staff failed to report the suspected Improper care of a resident to the Director immediately and after hour pager was not contacted.

Failure to notify the Director of an incident immediately did not pose a risk to the resident's care or safety

Sources: Critical Incident (CI), Resident's clinical records and interview with staff. [741104]

WRITTEN NOTIFICATION: Pain Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)
Required programs
s. 53 (2) Each program must, in addition to meeting the requirements set out in

section 34,
(b) provide for assessment and reassessment instruments. O. Reg. 246/22, s. 53 (2).

The Licensee has failed to comply with the requirement to provide for assessment instruments under home's Pain Management Program .

Rationale and Summary
The home's Pain Management Program directs to complete and document an assessment using the Pain Assessment form in Point Click Care (PCC), when it is reported that pain is present.

On a day in April 2023, - the Staff were informed that a Resident was complaining of pain. Analgesic was given as per medical directive but pain assessment was not completed.

On a day in March, the Staff verified that pain assessment form is to be completed whenever resident experiences pain. The Resident was expressing pain and it this concern was brought forward to the staff but Pain assessment in Point Click Care (PCC) was not completed.

On a day in March, the Administration Staff verified that resident was not able to verbalize pain. The Pain assessment form in Point Click Care (PCC) needs to be completed when pain is identified, and it was not completed.

There was a moderate risk of harm to the resident when staff did not comply with the home's policy.

Sources: Resident's clinical records, Pain Management Program Nursing and Interviews with staff. [741104]

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 Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 6.1 that the licensee shall ensure that personal protective equipment (PPE) is available and accessible to staff, appropriate to their role and risk level.

During an observation on a day in March 2024, the Inspector noted that resident had a contact droplet precaution sign on their doorway, instructing staff to wear long-sleeved gowns, gloves and masks as part of their PPE. The Inspector observed the PPE set up outside the room and noted that there were no gowns readily available for staff to utilize when entering the resident's room.

In a follow up observation on a day in March 2024, the Inspector observed the PPE set up for the resident's room with the staff. The staff confirmed there were no gowns available for staff use in the yellow PPE bag on the resident's room door, and indicated that it is the responsibility of all staff to ensure that the yellow PPE bags for the additional precautions rooms are fully stocked with the appropriate PPE, and

that staff should have ensured that this requirement was appropriately met.

Failure to provide the appropriate PPE at point of care for staff may have increased the likelihood of staff not wearing the required PPE, which may contribute to transmission of infections.

Sources: Observation, and interview with staff. [000767]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 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 staff participated in the implementation of the Infection Prevention and Control (IPAC) Program, related to hand hygiene for staff.

Rationale and Summary
During meal services on a day in March 2024, a staff was observed assisting residents with their meals in the Resident Home Area (RHA) dining room. The staff was seen engaging in different tasks, including collecting soiled dishes, touching cleaned dishes and food products, touching residents on their shoulders in a caring way, and touching residents' personal devices without performing hand hygiene in between tasks. The staff was made aware of this observation prior to them existing the dining room.

In a follow up discussion on a day in March 2024, a staff acknowledged that they did not perform hand hygiene in between tasks during meal services, and that they should have performed hand hygiene as required.

Sources: Dining room observation, and interview with Staff. [000767]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift the resident was monitored for symptoms of infection in accordance with the IPAC standard issued by the Director under subsection (2).

Rationale and Summary

According to the IPAC Standard for Long-Term Care Homes (LTCHs) revised September 2023, section 3.1 (b) and (f), the licensee shall ensure that the following surveillance actions are taken: Ensuring that surveillance is performed on every shift to identify cases of healthcare acquired infections (HAIs), device-associated infections and Antibiotic Resistant Organisms (AROs), and ensuring that surveillance information is tracked and entered into the surveillance database and/or reporting tools.

A review of the resident's clinical records, indicated that the resident was not monitored for symptoms of infection on every shift on a day in March 2024. The resident's clinical record summary showed that the resident was monitored on two shifts only on that day.

In an interview on a day in March 2024, with the registered staff stated that the home did not monitor or record the resident's symptoms of infection for all three shifts, and that the home should have ensure that the resident was monitored on every shift as required to prevent further symptoms of infection.

By not monitoring a resident for symptoms of infection on every shift, this may contribute to further health risks for a resident.

Sources: Interview with staff, and resident's clinical records.
[000767]

COMPLIANCE ORDER CO #001 Maintenance services

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

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

- Create and put a plan in place to ensure that all equipment is secured in resident rooms.
- Provide education and re-training for all relevant staff on procedures installing the equipment.
- Conduct the appropriate equipment Audit for a minimum of two months until the home has no further concerns.
- The home must keep a record of education and audits and actions made based on audit results for Long- Term Care Home(LTCH) inspector review

Grounds

The licensee has failed to ensure that the procedures in place for routine preventative maintenance are complied with.

Rationale and Summary

On a day in February 2024, a resident attempting to get to the bathroom, had an unwitnessed fall and sustained an injury. Two staff confirmed that resident was at risk for fall and a piece of equipment was in place whenever resident was in bed as a falls prevention intervention.

On a day in March 2024, a one staff verified that equipment was not functional at the time resident had a fall.

On a day in March 2024, the second staff verified that the equipment was on the ground, and it was not functional at the time of the fall.

During the observation and interview done with Staff on a day in March 2024, the Administration Staff identified that the equipment was not secured accordingly as a preventative measure which resulted in a malfunction of the equipment. There are no routine audits conducted for monitoring the equipment.

Sources: Resident's clinical records, video and picture of bed alarm, Equipment, Equipment and Preventative Maintenance, interview with staff. [741104]

This order must be complied with by May 8, 2024

COMPLIANCE ORDER CO #002 Compliance with manufacturers' instructions

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

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

1. Use and maintain equipment in accordance with the Manufacturer's Instructions.

2. Have Manager review for themselves and re-educate all relevant staff on the use of the Equipment and its use.
3. Record information daily and document on the log sheet.
4. Keep a record of the training materials used and the date all education was completed for inspector review.

Grounds

Compliance with manufacturers' instructions.

Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Specifically, the licensee has failed to ensure that the equipment was maintained in accordance with manufacturer's instructions.

Rationale and Summary

The Equipment Manual and Policy both state an operating process should be followed regarding daily usage and information regarding the equipment should be recorded daily on a log.

The logs used by the Staff for the months of December 2023, January, February, and March 2024 were not completed daily and 25 out of 34 days the information recorded deviated from policy.

The Staff stated they followed another process to manage deviations, which was not an acceptable practice according to the manufacturer's instructions.

On a day in February 2024, when resident sustained an injury, the manufacturer instructions and policy of the equipment was not followed.

Failure to ensure the equipment was maintained as per the manufacturer's instructions put resident at risk of an injury.

Sources: Record review of the equipment logs, Manual and Policy, interview with staff and Administration Staff, Resident's clinical records, Critical Incident. [741863]

This order must be complied with by: April 8, 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.