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

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Original Public Report

Report Issue Date: October 30, 2024
Inspection Number: 2024-1366-0004
Inspection Type: Complaint Critical Incident
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Erin Meadows, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 21-22 and 24-25, 2024.

The following intake(s) were inspected:

- Intake: #00124002 - Critical Incident (CI): 2881-000035-24 - Sexual abuse to resident by resident.
- Intake: #00124116 - CI: 2881-000036-24 - Improper/incompetent care of resident by staff.
- Intake: #00124660 - Complaint with concerns regarding resident to resident sexual abuse, and responsive behaviours.

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 11.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to live in a safe and clean environment.

The licensee has failed to ensure that a resident had the right to live in a safe and clean environment upheld.

Rationale and Summary
On a specified date in August 2024, resident A entered resident B's room and laid down in their bed, while resident B was already in the bed. Resident A soiled resident B's bed. Staff were alerted, responded, and separated and assessed both residents. There was no indication that any abuse had occurred.

Resident B's rights for a safe and clean environment were violated when resident A soiled their bed and caused them fear.

Sources: CI: 2881-000035-24, progress notes, interviews with staff and the Administrator.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
On a specified date in April 2024, resident A was found in resident B's room. The next day, resident B's SDM informed the home that resident B stated that resident A had gone in their room near their bed. There was no documentation to support that resident B's SDM was notified about resident A being in resident B's room.

The SDM complained to the home that they were not notified about the incident.

Failure to inform resident B's SDM regarding the incident, did not allow them to participate in the development and/or implementation of the resident's plan of care.

Sources: Resident's' progress notes, interview with Administrator and complainant.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
A resident's plan of care indicated that they were to use a bed alarm while in bed as a falls prevention intervention.

On a specified date in August 2024, it was noted that the resident's bed alarm was not applied to their bed. This was documented on the day prior by evening and night shift staff as not "NA" (not applicable).

Staff submitted a maintenance request on to have it replaced and was documented as replaced two days later.

Failure to ensure that the resident's bed alarm was in use put the resident's safety at risk.

Sources: Resident's plan of care, progress notes, documentation; interview with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
A resident required two-person transfer assist for safe transfer.

On a specified date in August 2024 a resident was transferred by two staff from bed to chair. During transfer, the sling tore and the resident was lowered to the floor.

It was noted after the incident that an incorrect, poor conditioned, sling was used to transfer the resident. Staff noted another resident's name was written on the sling.

The staff did not check and assess the functionality and name on the harness prior to use, which should have been done according to the home's mechanical lifts policy, that indicated staff are to "check that all lift attachments (i.e. slings, hooks, straps, and supports) are available, appropriate, and of the correct size."

As a result, the resident sustained several injuries.

Failure to use a safe transferring device when assisting a resident with transfer placed the resident at risk of a fall and injury.

Sources: Observations of sling, interviews with staff, resident clinical records, CI:

2881-000036-24.

WRITTEN NOTIFICATION: Dress

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 44
Dress
s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

The licensee has failed to ensure a resident was dressed appropriately, suitable to the time of day.

Rationale and Summary
On a specified date in October 2024, in the late morning hours, a resident was observed sleeping in their bed wearing a shirt without pants, only wearing a continence brief, covered with a blanket.

The home's policy, titled A.M. / H.S. Care, indicated the home was to "assist the resident to dress or undress for the day/bedtime, allowing them their choice/preference." Review of the resident's clinical records did not indicate there was a resident or family preference for the resident to be placed in bed without pants during the time of the observation. This was confirmed with staff.

Failure to ensure the resident was not dressed appropriately, suitable to the time of day, placed a risk for their dignity to be impacted.

Sources: The home's policy, titled "A.M/H.S. Care", resident observations, interviews with staff, resident clinical records.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident's individualized plan to manage bowel and bladder continence was implemented.

Rationale and Summary
A resident's Individual Care Service Plan and Care Plan indicated "team member(s) to assist/encourage resident with continence care upon awakening, before attending the dining room, after meals, and before bedtime, and as needed".

On a specified date in October 2024, a staff reported they changed a resident's brief in the early morning hours. The resident was observed being fed breakfast and did not have their brief checked or changed after. The resident's brief was checked and changed prior to lunch and was soiled.

Failure to provide continence care and bowel management according to the resident's individual plan increased the risk of a missed continence care opportunity,

which may have minimized the resident's comfort and dignity.

Sources: Observations, interview with staff, resident's clinical records.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 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 where the Regulation required the licensee of a long-term care home to carry out every standard or protocol issued by the Director with respect to infection prevention and control, the Director's issuance was complied with.

In accordance with the Infection Prevention and Control (IPAC) Standard for long-term care homes, Standard 10.1, the licensee was required to ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). The ABHR shall be easily accessible at both point-of care and in other common and resident areas, and any staff providing direct resident care must have immediate access to ABHR that contains 70-90% alcohol concentration.

Rationale and Summary
On a specified date in October 2024, the home was in confirmed respiratory

outbreak on two Neighbourhoods.

An Inspector observed three wall hanging ABHR dispensers empty in a specified Neighbourhood lounge area, and one non-functional wall hanging ABHR dispenser in the Neighbourhood hallway. This was confirmed by two staff.

The Inspector noted a staff attempting to obtain ABHR from one of the dispensers in the lounge, without success. The staff proceeded toward the home area entrance door to obtain ABHR.

Failure to have filled and functional dispenser bottles of ABHR easily accessible in common and resident areas may have resulted in the transmission of infectious agents.

Sources: Observations and interviews with staff.