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

Hamilton Service Area Office
119 King Street West, 11th Floor
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Telephone: 1-800-461-7137
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Original Public Report

Report Issue Date October 3, 2022
Inspection Number 2022_1339_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Schlegel Villages Inc.

Long-Term Care Home and City
The Village of Tansley Woods, Burlington

Lead Inspector
Daria Trzos (561)

Inspector Digital Signature

Additional Inspector(s)
Kelly Hayes (583)

Kelly Hayes Digitally signed by Kelly Hayes
Date: 2022.10.20 12:59:40 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 27, 28, 29, 2022 and July 5, 6, 7, 8, 11, 12, 13, 14, 15, 2022.

The following intake(s) were inspected:

- Intake # 010275-22 (Complaint) related to a fall that resulted in death
- Intake # 010057-22 Related to a fall that resulted in death
- Intake # 009675-22 (Complaint) related to multiple care concerns
- Intake # 020239-21 (Complaint) related to skin and wound
- Intake # 006963-21 Related to unexpected death
- Intake # 003292-21 Related to suspected abuse/unsafe transfer

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

- Care and Services
- Continence Care
- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Skin and Wound Prevention and Management

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INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NCR#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCHA, 2021 s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that set out, clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
The frequency and time of day staff thought the resident should be toileted were different. The toileting plan of care identified the level of assistance the resident required but did not identity when or how often the resident should be toileted to facilitate bowel continence, prevent constipation and be kept clean, dry and comfortable.

During the inspection the toileting care plan was revised, providing clear direction as to when staff were to toilet the resident, and this revision better reflected care staff were already providing to keep the resident clean dry and comfortable.

Sources: Observations, toileting and continence plan of care, continence assessment, task records and progress notes; and interviews with Registered Practical Nurse and PSW staff.

Date Remedy Implemented: July 11, 2022. [583]

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL]

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102(2)(b)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2002, issued by the Director with respect to infection prevention and control was complied with.

Rationale and Summary
On June 27, 2022, Inspectors #561 and #583 observed lunch service on a home area. None of the residents were assisted or encouraged to perform hand hygiene prior to the meal service.

Interviews with staff and the home's policy confirmed it was an expectation that residents were to be assisted to sanitize hands prior to meals or at least encouraged to do so.

Sources: Observations; Interviews with PSW, RN and IPAC leads; review of the home's policy called Hand Hygiene (June 24, 2021). [561]

WRITTEN NOTIFICATION [NEGLECT]

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 19 (1)

The licensee failed to ensure that a resident was protected from neglect.

Section 5 of the Ontario Regulation 70/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

On a day in 2021, a PSW failed to provide a resident the assistance they required completing two unsafe transfers in a row. The resident was injured and the staff member did not immediately call for help or notify the registered nursing staff about the injuries the resident sustained during their shift.

When the management team at the home became aware a resident had injuries of an unknown cause they began to speak to staff, and identified staff were aware of the incident.

The following pattern of inaction occurred that jeopardized the resident's health, safety and well-being over a three-day period following the incident.

The resident did not receive the assessments and monitoring they required. The alleged staff member continued to provide care to the resident. The residents SDM was not made aware of the incident and interventions were not put in place to support the resident.

Once the licensee became aware of the incident immediate action to taken to support the health, safety and well-being of the resident. After the homes investigation was completed the home took action and completed education to all staff involved related to reporting, safe transferring and assessments.

Sources: The home's investigation notes; interviews with staff; resident progress notes, skin and wound assessments and pictures, care plan, bathing task report; Prevention of Abuse and Neglect Policy (Tab 04-06); and the daily shift report (February 21-24,2021). [583]

WRITTEN NOTIFICATION [REPORTING]

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24 (1)1

The licensee has failed to ensure that a person who had 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.

Rationale and Summary

On a day in 2021, a PSW did not notify the home when they provided improper care to a resident that resulted in hard to the resident. Another PSW working with the staff member became aware of the incident after insisting to know further details as to how a resident was harmed. Other staff working the same shift became aware of what occurred and observed the resident to have injuries.

Staff encourage the PSW involved to report the incident and thought they had communicated with the Registered Nursing staff. Registered staff denied being aware of what occurred.

The suspected improper care of the resident was not reported until three days later, after the leadership team became aware of the incident.

Sources: The home's investigation notes; LTCH's after-hours report; interview with Assistant General Manager (AGM) and other staff; the home's Prevention of Abuse and Neglect Policy (Tab 04-06). [583]

WRITTEN NOTIFICATION [UNSAFE TRANSFER]

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 36

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

Rationale and Summary
A PSW staff member completed two unsafe transfers in a row in 2021 that resulted in injuries to a resident.

The PSW involved did not follow the resident's plan of care or the home's policies. The PSW involved confirmed in interviews that they did not use safe transferring and positioning techniques when assisting the resident at the time of the incident. .

The resident was put at risk when the PSW used unsafe transferring techniques. The resident sustained serious injuries.

Sources: The home's Mechanical Lifts Policy (Tab 04-66 A); the home's investigation notes; interviews with involved PSW, AGM and other staff. [583]

WRITTEN NOTIFICATION [SKIN ASSESSMENT]

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 50 (1) 2.

The licensee has failed to ensure that a resident's alterations in skin were assessed and monitored when observed by staff.

In accordance with O. Reg 79/10 s. 8 (1) (b), the licensee was required to ensure that the skin and wound program strategies to promote resident comfort, mobility and prevention of infection, including the monitoring of residents was complied with.

Specifically, staff did not comply with the "Skin and Wound Care Program" policy that directed PSWs to document and report abnormal or unusual skin concerns (including bruises/redness) to the registered nursing team members so altered skin integrity could be assessed and monitored,

Rationale and Summary

On a day in 2021, a resident received an initial skin assessment which identified two areas of altered skin, approximately 48 hours after the resident was unsafely transferred and sustained injuries. The home's investigation identified that PSW staff were aware of the altered skin integrity on the day of the incident and the following day but had not reported or documented their findings to registered nursing staff.

Three days following the incident, the resident received an initial head-to-toe skin assessment which identified altered skin integrity to five areas, of unknown cause. A Nurse Practitioner also assessed the areas and indicated the trauma/injury appeared to have occurred a few days prior to their assessment.

As a result of PSW staff not reporting to registered staff when they observed the residents altered skin, the resident's skin assessments were delayed, pain to the areas of altered skin were not assessed and the licensees investigation was delayed.

Sources: The home's Skin and Wound Care Program Policy (Tab 04-78); resident skin and wound assessments and pictures; progress notes; the home's investigation notes. [583]

WRITTEN NOTIFICATION [CRIMINAL RECORD CHECK]

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 215 (2) (b)

The licensee has failed to ensure that a criminal reference check was conducted within six months before a staff member was hired.

Rationale and Summary
The staff members criminal reference check was conducted 13 months before the staff member was hired.

Sources: Police Service Criminal Record Search document; Staff members Offer of Employment; and interviews with the AGM. [583]

WRITTEN NOTIFICATION [PROVIDE DECLARATION]

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 215 (4)

The licensee has failed to ensure a signed declaration disclosing the following was provided by the staff member with respect to the period since the date of their last police record check was conducted:
1. Every offence with which the person has been charged under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada) and the outcome of the charge.
2. Every order of a judge or justice of the peace made against the person in respect of an offence under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), including a peace bond, probation order, prohibition order or warrant to arrest.
3. Every offence of which the person has been convicted under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada). O. Reg. 451/18, s. 3 (1).

A signed declaration required under subsection (4) 1-3, with respect to the period since the date of staff members last police record check to date of hire was not found. A different management team was at the home at time of hire.

Sources: Police Service Criminal Record Search document; Police Service Occurrence Reports; Staff members Offer of Employment; and interviews with the AGM. [583]

WRITTEN NOTIFICATION [NOTIFY OF CHARGE AND OUTCOME]

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NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 215 (5) (a) (b)

A staff member failed to notify the long-term care home after they were made aware they had been charged and after a charge was otherwise disposed of.

While employed at the Village of Tansely Woods, a staff member failed to notify the home they had been charged iand failed to notify the home after the charge was otherwise disposed of.

In an interview with the management, it was shared the home was not aware and they had no record of this in the home's employee files.

Sources: Police Service Criminal Record Search document; Police Service Occurrence Reports; Staff members Offer of Employment; and interviews with the AGM. [583]

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