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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 21, 2021	2021_875501_0021	005559-21, 006395-21, 006657-21, 007106-21, 012455-21, 012778-21	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 Taunton Mills
3800 Brock Street North Whitby ON L1R 3A5

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

SUSAN SEMEREDY (501), JULIE DUNN (706026)

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): September 16, 17, 20, 21, 22, 23, 2021.

The following intakes were inspected in this critical incident inspection:
Log #012778-21, #012455-21, #005559-21 and #007106-21 related to the prevention of falls;
Log #006395-21 related to the prevention of abuse and neglect; and,
Log #006657-21 related to a follow-up to Compliance Order #001 from inspection #2021_595110_0004 regarding dining and snack service with a compliance due date of June 30, 2021.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), Director of Nursing (DON), Assistant Director of Nursing (ADON), Director of Environmental Services (DES), Assistant Director of Environmental Services (ADES), Registered Dietitian (RD), Kinesiologist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Attendants (PCAs), students, residents, and substitute decision-makers.

During the course of the inspection, the inspectors observed resident and staff interactions, meal and snack services, and IPAC practices. The inspectors reviewed clinical health records, relevant home policies and procedures, the home's room temperature logs and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **1 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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist three residents with eating, including safe positioning of residents who required assistance.

Compliance order #001 related to O. Reg. 79/10, s. 73(1) from inspection 2021_595110_0004 issued on April 16, 2021 with a compliance due date of June 30, 2021 is being re-issued as follows:

A snack time observation identified a resident in an unsafe position for eating while a PCA was in an inappropriate position for assisting the resident. The resident was unable to tolerate the food. On another day, in another home area, PCAs were also observed to be in inappropriate positions for assisting two residents with eating. All three residents were identified to be at nutritional risk and two of the residents had difficulties tolerating food and fluids.

An interview with the Registered Dietitian (RD) indicated that residents should be sitting upright and those assisting with eating should be sitting at eye level with the resident in order for the residents to be in the best position to safely swallow and prevent incidents of coughing and choking.

Failing to ensure proper techniques are used to assist with eating, including safe positioning, for those that require assistance puts residents at actual risk of harm.

Sources: Observations, review of residents' clinical records and interviews with the RD and other staff members. [s. 73. (1) 10.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provided direct care to a resident related to their transfer needs.

In a resident's room, a sign was posted indicating the resident's transfer status. However, the resident's written plan of care specified a different transfer status. During interviews, staff members had conflicting awareness of the resident's transfer status. An interview with the DON confirmed clear direction was not provided to the staff related to

the resident's transfer needs.

Failing to set out clear direction to staff regarding their transfer status put the resident at actual risk of harm.

Sources: The resident's written plan of care, sign posted in their room and interviews with the DON and other staff. [s. 6. (1) (c)]

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

A resident who had a history of multiple falls had a fall where they sustained an injury. An intervention to prevent further injury indicated the resident was to wear protective devices. During an observation the resident was not wearing these devices. An interview with an RN indicated a PCA had forgotten to apply them and confirmed the resident should have been wearing these devices as that was the planned care for the resident.

In failing to ensure the resident was wearing protective devices, as set out in the resident's plan of care, there was risk of harm should the resident fall.

Sources: Critical Incident System (CIS) Report, the resident's clinical record including the written plan of care, an observation and interviews with an RN and other staff. [s. 6. (7)]

3.The licensee has failed to ensure that different approaches were considered in the revision of the resident's plan of care, when the care set out in the plan had not been effective related to risk for falls.

A resident who was ambulatory had a history of several falls and a recent fall which resulted in an injury. The falls prevention interventions in the resident's care plan did not include the wearing of protective devices until after the fall with an injury occurred.

During an interview with the kinesiologist, they stated that for an ambulatory resident having frequent falls they would try to implement protective devices. During an interview with the DON they stated that after the second or third fall, protective devices should have been implemented for the resident.

In failing to ensure that different approaches were considered in the resident's plan of care there was actual risk of injury.

Sources: Review of resident's clinical record, including care plan, progress notes and fall incident notes; interviews with the DON and other staff. [s. 6. (11) (b)]

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 the plan of care sets out clear directions to staff and others who provide direct care to the resident, the care set out in the plan of care is provided to the resident and that different approaches are considered in the revision of the resident's plan of care, when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure resident #005 was protected from abuse by resident #004.

Resident #005 was unable to physically protect themselves. Resident #004 was observed inappropriately touching resident #005. A previous similar incident had occurred involving the same residents. The physician adjusted medications for resident #004 and resident #005 was moved to another home area. The ADOC confirmed that resident #004 abused resident #005.

Failing to protect resident #005 from abuse put the resident at risk for actual harm.

Sources: Resident #005's clinical record, Critical Incident System (CIS) report and interviews with the ADOC and other staff. [s. 19. (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 residents are protected from sexual abuse, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1.1) The heat related illness prevention and management plan must, at a minimum,
(a) identify specific risk factors that may lead to heat related illness and require staff to regularly monitor whether residents are exposed to such risk factors and take appropriate actions in response; O. Reg. 79/10, s. 20 (1.1).
(b) identify symptoms of heat related illness and require staff to regularly monitor whether residents exhibit those symptoms and take appropriate actions in response; O. Reg. 79/10, s. 20 (1.1).
(c) identify specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents; O. Reg. 79/10, s. 20 (1.1).
(d) include the use of appropriate cooling systems, equipment and other resources, as necessary, to protect residents from heat related illness; and O. Reg. 79/10, s. 20 (1.1).
(e) include a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate. O. Reg. 79/10, s. 20 (1.1).

Findings/Faits saillants :

1.The license has failed to ensure that the heat related illness prevention and management plan for the home was implemented when the temperature reached 26 degrees Celsius or above, for the remainder of the day and the following day.

The home’s policy indicated that when there is a failure of the cooling system and until it is restored, procedures for extreme hot weather are to be followed. These procedures included posting a notice of hot weather, reducing the temperature by using portable air conditioners, fans, and cold fluids, substituting foods on the menu, providing extra fluids and modifying activities. A review of the home’s temperature logs indicated that temperatures measured and documented in a room on June 25, 26, 27 and 28, 2021, were above 26 degrees Celsius (ranging from 79.3 to 83.7 degrees Fahrenheit or 26.3 to 28.7 degrees Celsius). An interview with the Assistant Director of Environmental Services indicated they were aware of this failure and were in contact with their air conditioning repair service but did not liaise with the nursing department to ensure the resident in that

room did not suffer from any heat related illness. A review of the resident's clinical record and an interview with the Assistant General Manager (AGM) indicated that there was no evidence that nursing took any action when the temperatures were above 26 degrees Celsius for more than three days in the resident's room.

Failing to ensure the home implemented their heat related illness prevention and management plan put a resident at risk for harm.

Sources: The home's policy titled Extreme Hot and Cold Weather Conditions/Temperatures #04-32, the home's temperature logs and an interview with the AGM and other staff. [s. 20. (1.1) (b)]

2. The licensee has failed to ensure the heat related illness prevention and management plan identified specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents.

The home had two policies related to temperatures. One was for nursing to follow in the event of extreme hot and cold weather. The other was for environmental services for the prevention of hot weather illness prevention plan. Neither of these policies identified symptoms of heat related illness and the requirement for staff to regularly monitor whether residents exhibit those symptoms and take appropriate action. The AGM provided draft copies of the new policies the home has been developing and will soon be implementing which included the above requirements.

Failing to update the home's heat related illness prevention and management plan put residents at harm for heat related illness.

Sources: The home's current policies titled Hot Weather Illness Prevention Plan #01-06 last reviewed on October 19, 2020 and Extreme Hot and Cold Weather Conditions/Temperatures #01-06. The home's draft policies titled Water and Air Temperature #07-13 and Heat Related Illness Prevention and Management Plan #01-06 and interviews with the AGM and other staff. [s. 20. (1.1) (c)]

3. The licensee has failed to ensure that the heat related illness prevention and management plan included a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the

home, if any, and others where appropriate.

The home had two policies related to temperatures. One was for nursing to follow in the event of extreme hot and cold weather. The other was for environmental services for the prevention of hot weather illness prevention plan. Neither of these policies included a protocol for appropriately communicating the plan to the above mentioned parties. The AGM provided draft copies of the new policies the home has been developing and will soon be implementing which included these requirements.

Sources: The home's current policies titled Hot Weather Illness Prevention Plan #01-06 last reviewed on October 19, 2020 and Extreme Hot and Cold Weather Conditions/Temperatures #01-06. The home's draft policies titled Water and Air Temperature #07-13 and Heat Related Illness Prevention and Management Plan #01-06 and interviews with the AGM and other staff. [s. 20. (1.1) (e)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was documented in writing in at least two resident bedrooms in different parts of the home.

A review of the home's temperature logs indicated there were no temperatures documented for a resident room from July 25, 2021 to September 6, 2021 and in another resident room from August 16-20, 2021. An interview with the AGM indicated the home's computer temperature monitoring system failed to document these temperatures as was expected.

Failing to document the home's temperatures put residents at risk for heat related illness.

Sources: The home's temperature logs and an interview with the AGM and other staff. [s. 21. (2) 1.]

2. The licensee has failed to ensure that the temperature was documented in writing in one resident common area on every floor of the home.

The home was measuring and documenting temperatures in two dining rooms on different floors of the home. A review of the home's temperature logs indicated there were no temperatures documented for the one of the dining rooms from July 16, 2021 to September 4, 2021 and from September 8-12, 2021. Temperatures were not documented in the other dining room from July 21, 2021 to August 14, 2021 and from August 23 to September 4, 2021. An interview with the AGM indicated the home's computer temperature monitoring system failed to document these temperatures as was expected.

Sources: The home's temperature logs and an interview with the AGM and other staff. [s. 21. (2) 2.]

3. The licensee has failed to ensure that temperatures were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

A review of the home's temperature logs indicated the home did not document temperatures in any area of the home on August 15, 21, 22, 28, 29, 30, September 1, 2, 3, 2021. An interview with the AGM indicated the home's computer temperature monitoring system failed to document these temperatures as was expected.

Sources: The home's temperature logs and an interview with the AGM and other staff. [s. 21. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Critical Incident System (CIS) Report included any names of staff members who were present at or discovered the incident.

A CIS report was submitted to inform the Director that a resident had a fall and was taken to a hospital which resulted in a significant change in the resident's health status. The report did not include the names of any staff who were present or discovered the incident. In an interview a PCA acknowledged they and other staff heard the crash and attended to the resident. In a separate interview, the ADON confirmed they did not include the names of staff who discovered the incident.

Sources: CIS Report and interviews with the ADON and other staff. [s. 107. (4) 2. ii.]

Issued on this 27th day of October, 2021

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

Original report signed by the inspector.