Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central East Service Area Office
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Original Public Report

Report Issue Date July 19, 2022
Inspection Number 2022_1386_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 Taunton Mills - Whitby

Lead Inspector
Sami Jarour (570)

Inspector Digital Signature
Sami Jarour Digitally signed by Sami Jarour Date: 2022.07.26 16:12:27 -04'00'

Additional Inspector(s)
Inspectors Maria Paola Pistritto (741736) and Reethamol Sebastian (741747) were also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s):
June 9, 10, 13-16, 21, 23, 24, 2022.

The following intake(s) were inspected:

- Intake #005741-22, Follow up to Compliance Order (CO) #001 issued on April 12, 2022(A1), under Inspection Report # 2022_673672_0004(A1) related to O. Reg 79/10, s. 73. (1) with a compliance due date of April 18, 2022.
- Intake #005746-22, Follow up to Compliance Order (CO) #001 issued on March 23, 2022, under Inspection Report #2022_673672_0005 related to O. Reg 79/10, s. 229. (4) with a compliance due date of April 18, 2022.
- Intake #005742-22, Follow up to Compliance Order (CO) #002 issued on March 23, 2022, under Inspection Report #2022_673672_0005 related to the LTCHA, 2007, s. 19. (1) with a compliance due date of April 18, 2022.
- Intake #005743-22, Follow up to Compliance Order (CO) #003 issued on issued on March 23, 2022, under Inspection Report # 2022_673672_0005 related to O. Reg 79/10, s. 37 (1) with a compliance due date of April 18, 2022.
- Intake # 005744-22, Follow up to Compliance Order (CO) #004 issued on issued on March 23, 2022, under Inspection Report # 2022_673672_0005 related to O. Reg 79/10, s. 49. (1) with a compliance due date of April 18, 2022.

- Intake # 005745-22, Follow up to Compliance Order (CO) #005 issued on issued on March 23, 2022, under Inspection Report # 2022_673672_0005 related to O. Reg 79/10, s. 52. (2) with a compliance due date of April 18, 2022.
- Intake #011069-22, CIS #2902-000010-22 related to an allegation of abuse of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 73. (1)	2022_673672_0004	001	570
O. Reg. 79/10	s. 229. (4)	2022_673672_0005	001	570
LTCHA, 2007	s. 19. (1)	2022_673672_0005	002	570
O. Reg. 79/10	s. 37. (1)	2022_673672_0005	003	570
O. Reg. 79/10	s. 49. (1)	2022_673672_0005	004	570
O. Reg. 79/10	s. 52. (2)	2022_673672_0005	005	570

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Pain Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours

INSPECTION RESULTS

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.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the director was followed as it relates to ensuring point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary

On June 9, 2022, at 1128 hrs, a donning signage of personal protective equipment (PPE) was posted between two adjacent residents' rooms. No signage of any type of precautions for either room was posted; PPE caddy was placed in between the two rooms.

Interview with registered practical nurse (RPN) #104 indicated the PPE caddy was for resident #003. The RPN indicated a contact precautions signage should be placed on the door.

On June 9, 2022, at 1218 hrs, signage posted on door of resident #003's room indicating contact precautions.

Sources: Inspector #570's observations and Interview with RPN #104.

Date Remedy Implemented: June 9, 2022 [570]

NC#002 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the director was followed as it relates to performing hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary

On June 9, 2022, at 1133 hrs, personal support worker (PSW) student #102 was observed inside a resident's room and moving toward the door pushing a Hoyer lift; before exiting the room, PSW student #102 removed gloves and did not perform hand hygiene. The PSW student was observed putting on new gloves without performing hand hygiene.

Interview with PSW student #102 acknowledged they did not perform hand hygiene when they left resident's room.

Interview with the Director of Care (DOC) indicated that students were educated regarding IPAC including hand hygiene and that they will ensure PSW student #102 was re-educated.

On June 16, 2022, the Director of Care (DOC) provided Inspector #570 documentation that the PSW student was re-educated regrading IPAC including hand hygiene.

Sources: Inspector #570's observations and Interview with PSW student #102, Director of Care (DOC).

Date Remedy Implemented: June 16, 2022 [570]

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)

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the director was followed as it relates to environmental controls.

Rationale and Summary

IPAC standard #9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include:
e) Use of controls, including:
i. Environmental controls, including but not limited to, location/placement of residents' equipment, cleaning, making hand hygiene products available.

Inspector observed staff #109 wheeling residents in wheelchairs to their tables in the dining room. Staff #109 used their foot to push the brakes handle on two residents' wheelchairs.

Interview with staff #109 acknowledged that the brake handles are not considered clean when pushed by the feet and that they would not use their feet to apply breaks to wheelchair.

Interview with the Administrator indicated that using the feet to apply brakes on wheelchair was not an appropriate practice and that would contaminate the brake handles.

Failure to maintain clean environment including clean residents' equipment could contribute to the spread of infectious agents.

Sources: Inspector #570's observations, IPAC standards (April 2022), interviews with Staff #109 and the Administrator.

WRITTEN NOTIFICATION [REQUIRED PROGRAMS]

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 53. (1) 4

The licensee has failed to ensure that pain management program had been implemented in the home related to resident #001's pain assessment not being completed.

Rationale and Summary

Resident #001 reported they had a fall. A post fall assessment was completed and indicated that a PAINAD Extension was completed.

A review of the pain assessment on date of fall indicated the pain assessment instrument was initiated but not completed on same date.

Interview with RN #105 indicated the pain assessment instrument under assessment tab on point click care (PCC) is used to assess pain. The RN acknowledged the pain assessment tool for resident #001 was initiated but not completed.

Interview with the Director of Care (DOC) indicated the expectation is that staff should be completing the pain assessment

Failure to complete pain assessments could result in resident's pain not being managed.

Sources: Health records for resident #001, interviews with RN #105 and the DOC. [570]

WRITTEN NOTIFICATION [RESIDENTS' BILL OF RIGHTS]

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 3 (1) 1

The licensee failed to ensure resident #001's rights to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, was respected and promoted.

Rationale and Summary

During an interview with RN #117, the RN indicated that during medication pass with student nurse present, resident #001 took medication by their hand and threw them behind the bed and on the floor. The RN indicated they reapproached the resident and administered the same medication that was picked up from the floor.

Interview with Student Nurse (SN) #118 confirmed that pills were picked from the floor and some from bed. The SN indicated that was not the practice they learnt at school but did not communicate that to the RN.

During separate interviews with the Director of Care (DOC) and the home's pharmacy consultant, they indicated that administering medication that was picked up from the floor was not an acceptable practice and that the RN should have discarded the medication, used a new pouch from the medication strip and reordered from the pharmacy.

Resident #001 was not treated with respect and dignity when they were administered medication that was picked up from the floor which could be contaminated and posing a potential risk to the resident.

Sources: Progress notes for resident #001, interviews with Student Nurse #118, RN #117, Pharmacy Consultant, and the DOC. [570]

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WRITTEN NOTIFICATION [REPORTING CERTAIN MATTERS TO DIRECTOR]

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 28. (1) 2

The licensee has failed to ensure a person who has reasonable grounds to suspect that grounds of abuse has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director regrading an allegation of sexual abuse toward a resident three days after the incident had occurred.

An interview with the Assistant Director of Care (ADOC) indicated they were called by the Manager on Call on same date of the incident, but they were not informed of all the details of the incident until three days after, when a CIS report was submitted.

Failure to immediately report allegations of abuse could put victims at an increased risk of further incidents.

Sources: CIS report, interview with the Assistant Director of Care (ADOC). [570]

WRITTEN NOTIFICATION [PREVENTION OF ABUSE AND NEGLECT]

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 24. (1)

The licensee has failed to ensure that resident #002 was protected from incidents of abuse.

Rationale and Summary

For the purposes of the Act and Regulation:
“Sexual Abuse” is defined as:
“any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member”

“physical abuse” is defined as:
“the use of physical force by a resident that causes physical injury to another resident”

A Critical Incident System (CIS) report was submitted to the Director, related to an allegation of abuse by resident #001 toward resident #002.

A review of progress motes for resident #002 indicated two previous encounters with resident #001:

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On an identified date, PSW staff found resident #002 in resident #001's room, sitting on resident #001's bed with resident #001's arm around resident #002's shoulder. Resident #002's was redirected from the room; it was noted that the zipper on the back of their clothing had been lowered. Resident was redirected out of room and alarm placed on resident #001's room.
On an identified date, resident #002 was found on the bed of resident #001 in resident #001's room. Resident #002 was redirected from the room.

On an identified date, RN #114 documented resident #002's side of face was red, and the resident was visibly upset and in tears. Resident #002's top was pulled halfway up. Similar incident had occurred on a previous date.

Physician #119 documented that the incident involving resident #001 and resident #002 was concerning as it was a repeat incident.

Interview with PSW #115 indicated, they were in another resident room assisting with toileting when the call bell went off and that call bell was not answered for five minutes. The PSW indicated resident #002 was going down the hallway away from resident #001's room. The resident was upset and there was a visible tear; RN #114 was notified.

Interview with RN #114 indicated, resident #002 was crying and weepy and their top was pulled up midway; there was some redness to the side of face and superficial scratches noticed after redness went down. The incident was not witnessed and the Manager on call was notified.

Interview with assistant director of care (ADOC) and the Behavioral Support Ontario (BSO) lead indicated resident #001's has impaired memory. The resident did not like people into their personal space and an intervention was put in place and would alert staff when somebody enters resident #001's room; staff are supposed to attend to it when alerted. The ADOC acknowledged that on the date of the incident, staff did not respond until after five-minutes. The ADOC/BSO lead indicated that resident #002 is cognitively impaired and required redirection. Resident #002 does not present any risk except of that of resident #001. The ADOC indicated that they were not informed of the details of the incident and the incident was not reported, investigated and one on one was not initiated until three days after the incident.

Interview with physician #119 indicated they were concerned about the incident since it had happened twice before with same resident #001 and since resident #002 has cognitive impairment and cannot tell what happened.

Failure to ensure resident #002 was protected from incidents of abuse could put resident #002 at increased risk of further incidents with increased risk of emotional and physical injuries.

Sources: CIS report, progress notes for resident #002, interview with PSW #115, RN #114, ADOC and the Physician. [570]