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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: February 8, 2024

Inspection Number: 2024-1386-0001

Inspection Type:
Complaint

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Taunton Mills, Whitby

Lead Inspector	**Inspector Digital Signature**
Deborah Nazareth (741745)	Deborah A Nazareth Digitally signed by Deborah A Nazareth Date: 2024.02.12 13:38:11 -05'00'

Additional Inspector(s)
Maria Paola Pistritto (741736)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 25, 26, 29 & 30, 2024.

The following complaints were completed in this inspection:

- One complaint related to resident care and infection prevention and control.
- One complaint related to responsive behaviours.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that interventions to minimize the risk of altercations and potentially harmful interactions between and among residents was implemented for residents #001 and #002.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care (MLTC) related to the Long-Term Care Home's (LTCH) management of responsive behaviours for residents #001 and #002. Residents #001 and #002 each had a history of responsive behaviours and using enhanced supervision was put in place for both residents for the safety of the residents and others.

Personal Support Worker (PSW) #103 reported that when residents #001 and #002 each had staff for enhanced supervision, the staff would cover breaks for each other leaving one staff providing supervision to two residents that required individual supervision. The Assistant Director of Nursing Care (ADNC) reported that both

residents exhibited responsive behaviours that posed a risk to others that required enhanced supervision. The ADNC confirmed that the staff were directed to cover each other's breaks and acknowledged if resident #001 was displaying behaviours the staff would not be able to monitor both residents. PSW #104 reported that due to the behaviours of resident #001, the staff could not supervise both residents and there would be a risk to other residents.

There was a risk for potentially harmful interactions between residents when a single staff was providing supervision to two residents with responsive behaviors.

Sources: Residents' care plan and clinical record. Interviews with staff. [741745]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 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 implement the Infection Prevention and Control (IPAC) Standard put forward by the Director.

Specifically, 9.1(e)(iii) of the Routine Practices precaution IPAC Standard for Long-Term Care Homes, 2022, last revised September 2023, states the licensee shall ensure the appropriate use of administrative controls including but not limited to, comprehensive IPAC policies and procedures, such as, checking the resident's

name on a personal care item prior to administration.

Rationale and Summary

A complaint was received by the MLTC regarding the personal care of a resident. A family member of a resident informed a Registered Nurse (RN) of a personal care item at the resident's bedside table with another resident's name on it. An investigation was conducted and concluded that a PSW applied the incorrect personal care item twice during the shift for the resident.

The PSW and the IPAC Lead confirmed it was the responsibility of the PSW to check the personal care item's labeled name prior to administration.

Failure to check the labeled name on personal care items prior to administration put the resident at risk for transmission of infectious agents.

Sources: Progress notes and interviews with staff. [741736]