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

London Service Area Office
130 Dufferin Avenue 4th floor
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130, avenue Dufferin 4ème étage
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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
Nov 24, 2021	2021_797740_0028	015058-21, 016608-21, 016702-21	Complaint

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 at St. Clair
1800 Talbot Road Windsor ON N9H 0E3

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

SAMANTHA PERRY (740)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 26, 27, 28, 29, November 01, 02, 03, 04, 05, 08, 09 and 10, 2021.

The following intakes were completed within this Complaint inspection:
Log# 015058-21 related to allegations of the unmet resident's care needs;
Log# 016608-21 related to allegations of resident neglect; and
Log# 016702-21 related to resident injuries of unknown origin.

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Nursing Care, Assistant Directors of Nursing Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

The inspector(s) also made various observations, including Infection Prevention and Control practices, and reviewed residents' clinical records.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure residents #001 and #004's medications were administered in accordance with the directions for use specified by the prescriber.

A complaint received by the Ministry of Long Term Care (MLTC) reported resident care concerns related to medications.

Residents #001 and 004's clinical records documented they were to have certain medications administered as per the home's medical directives. These medications were not administered as per the medical directives and in accordance with the directions for use specified by the prescriber.

Registered Practical Nurse (RPN) #107 and Director of Nursing Care (DNC) #102 said there was no reason why resident #001 and #004 would not have had these medications administered and should have. The risk to residents #001 and #004 was increased when the licensee failed to administer the residents' medications in accordance with the directions for use specified by the prescriber.

Based on interviews and record review the licensee failed to ensure medications were administered in accordance with the directions for use specified by the prescriber.

Sources: Follow Up Question Reports (ADL – Continence Bowel and Bladder) and eMARs on PCC; the Schelgel Villages Move-In / Return to Village Medication Orders document retrieved from the residents' paper charts and interviews with management and staff. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #001's plan of care was provided to the resident as specified in the plan.

A complaint received by the Ministry of Long Term Care (MLTC) reported resident care concerns.

Resident #001's plan of care documented the resident was to be specifically positioned to best meet their care needs. On multiple occasions and confirmed in an interview with Registered Practical Nurse (RPN) #104, the resident was not consistently in that position as specified in the resident's plan of care.

Based on observations, interviews and record review the licensee has failed to ensure the resident's plan of care was provided to the resident as specified in the plan.

Sources: Observations, resident #001's care plan, individual care service plan, plan of care special instructions on PCC, and progress notes; interviews with management and staff. [s. 6. (7)]

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 by providing resident #001's care needs as specified in the resident's plan of care, 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 #002 was protected from neglect by the licensee or staff when the resident's multiple care needs were not met.

Ontario Regulation 79/10 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home's policy, "subject: Prevention of Abuse and Neglect" states, "Schlegel Villages has zero tolerance with respect to abuse of any kind, including physical, sexual, emotional, verbal, financial and neglect, from any person (team members, residents, families, visitors, volunteers, students, contracted staff, agency staff, or companions). Furthermore, the policy defines neglect as, "The failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A complaint received by the Ministry of Long Term Care (MLTC) reported unmet resident care concerns.

Resident #002's clinical records documented a number of care concerns related to continence, infection prevention and control and dining, requiring intervention. However, there was no documented communication with the leadership team or notification to the physician to address the care concerns, and at times interventions were not implemented until weeks later.

ADNC #100 said communication with the physician and leadership team as well as interventions to meet the resident's care needs related to their care concerns should have been initiated sooner. The risk to resident #002, co-residents and staff was increased when the licensee failed to respond to the resident's care needs.

Based on observations, interviews and record review the licensee has failed to ensure the resident was protected from neglect from the licensee or staff.

Sources: Observations, resident #002's care plan, eMAR, follow-up question report, lab results, and progress notes; the home's policies, and interviews with management and 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 by ensuring resident #002 and all other residents' care needs are met and are protected from neglect by the licensee or staff, to be implemented voluntarily.

Issued on this 25th day of November, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SAMANTHA PERRY (740)
Inspection No. / No de l'inspection :	2021_797740_0028
Log No. / No de registre :	015058-21, 016608-21, 016702-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 24, 2021
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village at St. Clair 1800 Talbot Road, Windsor, ON, N9H-0E3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tammy Roberts

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 131 (2).

Specifically the licensee must:

A) Educate all registered staff regarding how medication specific medical directives are to be administered to all residents, including but not limited to, defining when and how registered staff should administer the medications.

B) A written record will be maintained by the home including,
- The content of the materials referenced to educate registered staff;
- The dates of each education session with an attendance list, including printed names
and signatures of all attendees;
- The name of the staff member providing the education for registered staff.

Grounds / Motifs :

1. The licensee has failed to ensure residents #001 and #004's medications were administered in accordance with the directions for use specified by the prescriber.

A complaint received by the Ministry of Long Term Care (MLTC) reported resident care concerns related to medications.

Residents #001 and 004's clinical records documented they were to have certain medications administered as per the home's medical directives. These medications were not administered as per the medical directives and in accordance with the directions for use specified by the prescriber.

Registered Practical Nurse (RPN) #107 and Director of Nursing Care (DNC) #102 said there was no reason why resident #001 and #004 would not have had these medications administered and should have. The risk to residents #001 and #004 was increased when the licensee failed to administer the residents' medications in accordance with the directions for use specified by the prescriber.

Based on interviews and record review the licensee failed to ensure medications were administered in accordance with the directions for use specified by the prescriber.

Sources: Follow Up Question Reports (ADL – Continence Bowel and Bladder) and eMARs on PCC; the Schelgel Villages Move-In / Return to Village Medication Orders document retrieved from the residents' paper charts and interviews with management and staff. (740)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of November, 2021

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Samantha Perry

Service Area Office /
Bureau régional de services : London Service Area Office