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

London District
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Original Public Report

Report Issue Date: December 22, 2023
Inspection Number: 2023-1474-0007
Inspection Type: Complaint Critical Incident
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village at St. Clair, Windsor

Lead Inspector	**Inspector Digital Signature**
Adriana Congi (000751)	Adriana Congi Digitally signed by Adriana Congi Date: 2024.01.12 12:47:45 -05'00'

Additional Inspector(s)
Terri Daly (115)
Jennifer Bertolin (740915)
Stacey Sullo (000750)
Cassandra Taylor (725)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 14-17, 20-21, 23-24, 27-30, 2023 and December 1, 2023.

The following intakes were inspected:

- Intake #00095555, intake #00098469, and intake #00099735 were related to responsive behaviours;
- Intake #00095875 and intake #00100738 were related to falls;
- Intake #00096761 was related to resident care and support services, prevention of abuse and neglect, medication management, reporting and complaints, and food, nutrition and hydration;

- Intake #00099911 was related to skin and wound prevention and management;
- Intake #00100502 was related to resident care and support services; and
- Intake #00100569 was related to continence care

The following intakes were completed in this inspection:

- Intake #00101673; intake #00094775; intake #00095627; intake #00097238; and intake #00098943 were related to falls prevention and management.

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Based on assessment of resident

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
Based on assessment of resident
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee failed to ensure that care set out in the plan of care was based on an assessment of the resident's needs.

Rationale and Summary
On observation, a registered staff completed a vitals check on a resident. The registered staff indicated that one of the vitals was out of normal range for the resident, could be inaccurate and would recheck the resident later.

No documentation was noted relating to the assessment or reassessment of the resident.

During an interview with the Director of Care (DOC), they indicated the expectation would have been for the registered staff to recheck the vitals immediately, to verify the accuracy, and to notify the physician if the vitals were out of range.

Sources: Observation, resident's medical records and staff interviews
[725]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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.

The licensee failed to ensure that a falls prevention strategy was provided as specified in the plan.

Rationale and Summary
Review of resident's care plan indicated that staff must ensure appropriate safety devices are in use. Review of the Falls Incident report indicated that no falls prevention strategies were being used at time of a fall.

During an interview with Assistant Director of Nursing Care (ADONC), the expectation would be for staff to ensure that safety devices are utilized according to the resident's care plan and confirmed that at the time of the fall, the falls prevention strategies were not in use.

Sources: Staff Interviews, Progress Notes, and Fall Incident Report [740915]

WRITTEN NOTIFICATION: Compliance with Manufacturers' Instructions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that staff used transfer equipment according to the manufacturer's instructions.

Rationale and Summary
According to documentation, staff used transfer equipment incorrectly which resulted in a fall. Review of the Falls Incident report indicated that a potential cause for the fall was due to equipment/assistive device contributing to the fall.

During an interview with a staff member, they stated that they did not apply the equipment appropriately.

During an interview with Program for Active Living (PAL) Director, stated the expectation would be that staff would use the equipment correctly with proper positioning, and that the equipment was not appropriately applied which caused the fall.

Sources: Progress Notes, Post Fall Assessments and Incident Reports, and Staff Interviews
[740915]

WRITTEN NOTIFICATION: Personal care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 36
Personal care
s. 36. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

The licensee has failed to ensure that individualized personal care was provided on a daily basis.

Rationale and Summary
A review of a resident's care plan and a physician progress note indicated an individualized plan for personal care.

A staff member stated that personal care was not provided per the individualized plan. The DOC confirmed that personal care must be provided per the individualized plan.

Sources: Resident's care plan, progress notes; and interviews with staff.
[000751]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe positioning techniques.

Rationale and Summary
A complaint was submitted to the Ministry of Long-term Care (MLTC) relating to safe positioning techniques. A review of records showed unsafe positioning techniques used by a staff member.

The DOC indicated the expectation would have been that the staff member use safe positioning techniques.

By not using safe positioning techniques, the staff member placed the resident at a potential risk for injury.

Sources: Resident records and staff interviews.
[725]

The licensee failed to ensure that staff used safe transferring techniques.

Rationale and Summary
A staff member was observed using an unsafe transferring technique.

During an interview the Director of PAL, they indicated that the technique used by the staff member was unsafe. The General Manager (GM) of the home indicated the expectation of the staff would have been to call the PAL team for an assessment and use a safe transferring technique.

Not using safe transfer techniques placed the resident at risk for potential injury.

Sources: Observation and staff interviews.
[725]

WRITTEN NOTIFICATION: Dining and snack service

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (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:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee failed to ensure that staff used safe positioning while assisting a resident to eat.

Rationale and Summary
A staff member was observed using unsafe positioning while assisting a resident to eat. The staff member acknowledged that they were not using safe positioning while assisting the resident.

The DOC indicated that the expectation would have been that staff ensure residents are in safe positioning while eating unless otherwise care planned for by the Registered Dietitian (RD). The DOC confirmed the resident was in an unsafe position at the time of the observation.

Not ensuring that the resident was in a safe position while eating, placed the resident at risk for a choking incident.

Sources: Observation and staff interviews.
[725]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 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 failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

Rationale and Summary
The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes stated the following:
9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include:

d) Proper use of personal protective equipment (PPE), including removal.
e) Use of controls, including:
i. Environmental controls, including but not limited to, the placement of residents' equipment and cleaning.

An observation of care being provided to a resident requiring additional contact precautions was made. A staff member was observed not removing PPE when required, placing the garbage pail on the resident's bed, and not cleaning the resident's equipment. Another staff member was observed doffing their PPE incorrectly.

During an interview with the staff member, they indicated they should not have put the garbage pail on the bed and should have changed the resident's bedding right away.

During an interview with the DOC, they indicated the expectation of staff would have been not to place the garbage pail on the resident's bed rather next to them on the floor and the resident's bed should have been remade after the garbage pail was placed on the bed. The DOC indicated that the other staff member did not follow the IPAC program and did not doff the PPE in the correct order. The DOC also indicated the resident's equipment should have been disinfected in the resident's room after the staff member doffed their PPE and completed hand hygiene.

Not following the IPAC program of the home placed the residents of the unit at risk for potential spread of infection.

Sources: Observation and staff interviews.
[725]

WRITTEN NOTIFICATION: Resident records

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274 (b) the resident's written record is kept up to date at all times.

The licensee failed to ensure that a resident's records were kept up to date at all time.

Rationale and Summary
On observation, a registered staff completed a vitals check on a resident. The registered staff indicated that one of the vitals was out of normal range for the resident, could be inaccurate and would recheck the resident later.

A review of the resident's medical records showed no documentation of the vitals taken.

During an interview with the registered staff, they indicated they did not record the vitals because it was out of the normal range for the resident.

During an interview with the DOC they indicated the expectation would have been for the registered staff to document the vitals so that the physician or Nurse Practitioner (NP) could see all the vitals when completing their assessments.

Sources: Observation, resident's medical records and staff interviews.
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