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: July 19, 2024

Inspection Number: 2024-1474-0002

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village at St. Clair, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 10, 11, 12, 13, 14, 17, 18, 2024

The following intake(s) were inspected:

- Intake: #00109344 - Critical Incident #3046-000014-24 - Alleged resident to resident abuse.
- Intake: #00112692 - Critical Incident #3046-000028-24 - Resident fall.
- Intake: #00116027 - Critical Incident #3046-000037-24 - Unexpected death of resident.
- Intake: #00117517 - Critical Incident #3046-000046-24 - Alleged resident to resident abuse.
- Intake: #00114722 - Follow-up Compliance Order #001 from inspection 2024-1474-0001. Compliance Due Date May 24, 2024, related to lingering offensive odour.
- Intake: #00112786 - Complaint r/t alleged abuse and care concerns.

The following intake was completed with this inspection:

- Intake: #00113288 - Critical Incident #3046-000029-24

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1474-0001 related to O. Reg. 246/22, s. 93 (2) (d) inspected by Terri Daly (115)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

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)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

Introduction
The licensee has failed to ensure that the care plan for a resident provided clear direction.

Rationale and Summary:
The care plan for a resident stated a specific intervention.

During an interview with an Assistant Director of Nursing (ADOC) they indicated that this intervention could be confusing.

During an interview with the Neighbourhood Coordinator (NC) they also identified that this intervention isn't likely and indicated that the care plan should be updated.

A review of the care plan after the interviews showed an updated intervention that provided clear direction to staff for this resident.

Sources: Review of resident chart and care plan, and interviews with staff.

Date Remedy Implemented: June 13, 2024

[000817]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

Introduction
The licensee failed to ensure that a resident's care plan was revised when care needs changed and an intervention was no longer required.

Rationale and Summary:
A review of a resident's care plan, showed a specific intervention.

An observation of the resident found that this intervention was not in place.

When interviewed, a Personal Support Worker (PSW) stated that the resident no longer required this intervention.

The Assistant Director of Care (ADOC) confirmed that this intervention, was no longer necessary.

The resident's care plan was revised and intervention was removed.

Sources: A resident's care plan, observation of the resident and interview with a PSW and ADOC.

Date remedy implemented: June 11, 2024.

[000823]

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
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:
1. Communication of the seven-day and daily menus to residents.

Introduction
The licensee failed to ensure that there was communication of the seven-day and daily menus to residents on a specific neighbourhood.

Rationale and Summary:
It was observed on one of the neighbourhoods that there was no seven-day or daily menu posted in the dining room for residents. When interviewed, a Registered Practical Nurse (RPN) stated that there was a television screen displaying the menu, but the residents damaged the screen. When asked about hard copies of the menus posted, the RPN stated the residents remove them.

The Assistant Director of Care (ADOC) on the neighbourhood was asked about the menus as they were not posted. ADOC stated they will resolve the concern.

An observation of the dining room showed the seven-day and daily menus posted after the discussion with the ADOC.

Sources: Observations, interviews with an RPN and an ADOC.

Date remedy implemented June 17, 2024.

[000823]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Introduction
The licensee failed to ensure that a resident had assessments/reassessments completed following a responsive behavioural episode.

Rationale and Summary:
A review of the chart for the resident did not identify any assessments/reassessment following a responsive behavioural episode. Assistant

Director of Nursing/Personal Expression Response Team (ADON/PERT) Lead was unable to show evidence of any assessments/reassessments being completed following the same incidence.

Failure to complete assessments/reassessments following the responsive behavioural episode placed the resident at risk based on staff not taking actions to respond to potential needs.

Sources: Review of resident chart and interviews with staff.

[000817]

WRITTEN NOTIFICATION: Administration of Drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

Introduction
The licensee has failed to ensure that a resident only received drugs prescribed for them.

Rationale and Summary:
The Prescriber's Digiorder form for a resident showed an order for a specific treatment cream, on a specific date. The MARs showed that a different treatment cream was added to the medication administration record for administration. Skin

and wound assessments for a specific area showed a deterioration in condition on two of the assessments.

During an interview with the consulting pharmacist, they confirmed that the two different treatment creams were not the same medicated creams and the order was not processed correctly.

The order not being processed correctly led to a resident receiving a drug that had not been prescribed for them. This impacted the resident by placing them at an increased risk of impaired skin integrity.

Sources: Review of Prescriber's Digiorder form, medication administration records, and interview with staff.

[000817]