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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: October 30, 2024

Inspection Number: 2024-1474-0004

Inspection Type:
Complaint
Critical Incident

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 dates: September 23-27, 2024 and October 1, 2024.

The following intakes were inspected:

- Intake #00122913 related to an outbreak,
- Intake #00123073 related to responsive behaviors,
- Intake #00124113 related to an outbreak,
- Intake #00124275 related to responsive behaviors,
- Intake #00124430 related to responsive behaviors,
- Intake #00124483 related to a complaint regarding plan of care,
- Intake #00125157 related to a complaint regarding personal care, infection prevention and control and complaint procedure,
- Intake #00125269 related to responsive behaviors,
- Intake #00125518 related to fall prevention and management; and
- Intake #00125520 related to a complaint regarding outbreak management.

The following intake was completed in this inspection:

- Intake #00121090 related to fall prevention and management.

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

Resident Care and Support Services
Continence Care
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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 the care set out in the plan of care for a resident, was provided to the resident as specified.
Rationale and Summary
A complaint was received by the Director related to laboratory testing for a resident not being completed.

Assistant Director of Care (ADOC) confirmed that it is the home's process to complete laboratory testing and that the resident should have had that completed when required. ADOC was unable to confirm with the lab whether the testing had been completed. ADOC also confirmed that the home's staff should have followed up on the results and had not.

Sources: Interviews with staff and review of resident's clinical records.

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to immediately forward to the Director a complaint received that alleged harm or risk of harm to a resident.

In accordance with to O Reg 246/22 s. 109. (1) A complaint that a licensee is required to immediately forward to the Director under clause 26 (1) (c) of the Act is a complaint that alleges harm or risk of harm, including, but not limited to, physical harm, to one or more residents.

Rationale and Summary

A complaint was received by the Director related to lack of hand hygiene before meals for a resident.

A complaint was lodged to the home on two separate dates regarding lack of hand hygiene which increased their risk of infection transmission. The home's complaint response form did not indicate that the complaint was forwarded to the Director.

General Manager (GM) confirmed that the home did receive this complaint and did not forward this complaint to the Director and should have.

Sources: Review of the home's complaints log, the complaint response form, emails from the complainant and interviews with the complainant and the GM.

WRITTEN NOTIFICATION: Duty to respond

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)
Powers of Family Council
s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

The licensee failed to respond to the Family Council in writing within ten days of receiving a concern or recommendation the Family Council had about the operation of the home.
Rationale and Summary
A concern related to lack of hand hygiene assistance for residents before meals was raised at a Family Council meeting with no response back from the home.

GM confirmed that the home had received a concern at the Family Council Meeting in regards to lack of hand hygiene for residents before meals and had not completed a written response to the Family Council.

Sources: Review of the Family Council Meeting minutes, interview with the GM and complainant.

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 1.
Training
s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.

The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in abuse recognition and prevention, at times or at intervals provided for in the regulations:

In accordance with O Reg 246/22 s. 261(2), the licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

Specifically, all direct care staff did not receive the required annual training in abuse recognition and prevention in 2023.

Rationale and Summary
General Manager (GM) stated that all staff did not complete the mandatory education for abuse recognition and prevention for 2023. Specifically, 110 out of 334 staff or 33% had completed it.

There was risk to residents related to lack of education of staff in abuse recognition and prevention.

Sources: Interviews with GM and review of the annual education report.

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 2.
Training
s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
2. Mental health issues, including caring for persons with dementia.

The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, were trained in Mental health issues, including caring for persons with dementia at times or at intervals provided for in the regulations:

In accordance with O Reg. 246/22 s. 261 (2), The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

Specifically, all direct care staff did not receive the required annual training in mental health issues, including caring for persons with dementia in 2023.

Rationale and Summary
General Manager (GM) stated that all staff did not complete the mandatory education for mental health issues, including caring for persons with dementia for 2023. Specifically, 37 out of 334 direct staff or 11% had completed it for 2023.

There was risk to residents related to lack of education of staff in mental health issues, including caring for persons with dementia.

Sources: Interviews with GM and review of the annual education report.

WRITTEN NOTIFICATION: Dealing with complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. A.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,

A. what the licensee has done to resolve the complaint, or

The licensee failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home a response was provided to the person who made the complaint and shall include an explanation of what the licensee had done to resolve the complaint.

Rationale and Summary
A complaint was received by the Director related to lack of hand hygiene before meals for a resident.

A complaint was lodged to the home on two separate dates regarding lack of hand hygiene. No response was received by the complainant in relation to what had been done to resolve the complaint.

The complaint response form of the home did not show any response or resolution on it.

The GM confirmed that the home did not respond to the complainant with resolution and should have.

Sources: Review of the home's complaints log, the complaint response form, emails from the complainant and interviews with the complainant and the GM.

WRITTEN NOTIFICATION: Direct Care Staff Training

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.

Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

The licensee failed to ensure that all direct care staff were educated relating to Falls prevention and management for the year 2023.

Rationale and Summary
During a review of the home's Falls prevention and management program the annual education provided to the staff was requested. The general manager (GM) provided the inspector with a piece of paper that indicated that 17% of the direct care staff in the home had completed the Fall education for the year 2023. In an interview with the GM, it was confirmed that the home's direct care staff had not completed the required annual fall education for 2023.

There was a risk to the residents that reside in the home related to direct care staff who had not completed the required annual Falls prevention training.

Sources: The home's education records and interview with GM.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must ensure that:

A) All direct care staff who may work on the specified home area complete education related to hand hygiene for residents. This education must be documented with date and times of education, who attended, who provided the education and the contents of the education.
B) Information and education are provided to all residents and families in relation to the home's hand hygiene program as it pertains to residents.
C) Once education has been completed as above, audits are performed daily for two weeks on residents being assisted with hand hygiene on the home area before meals and must include all meal services. Once the initial two weeks of audits is completed then weekly audits are to be performed until this order is complied. Documentation with the outcome of the audits, any actions taken including any education provided, dates, times and who completed the audits are to be kept.

Grounds
The licensee has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.
Specifically, the licensee failed to ensure that residents were provided assistance to perform hand hygiene before meals.

Rationale and Summary

The IPAC standard- Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes of April 2022, Revised September 2023 states under section 10.2:
The hand hygiene program for residents shall include:
c) Assistance to residents to perform hand hygiene before meals and snacks

In an observation of a meal service on a home area, it was noted that no residents were provided assistance or supported to perform hand hygiene before their meal.

Two residents stated that were not offered assistance or support to sanitize their hands before all meals. General Manager (GM),confirmed they would expect staff to assist residents with hand hygiene before each meal.

There was risk to residents related to infection transmission when they were not provided with assistance with hand hygiene before meals.

Sources: Observations of lunch service and interviews with GM and residents.

This order must be complied with by December 20, 2024

COMPLIANCE ORDER CO #002 CMOH and MOH

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1. Complete an inventory of the alcohol based hand rub (ABHR) stock with expiry dates and keep this inventory list to ensure ABHR is not expired and accessible for use.
2. The IPAC lead is to develop and implement a process to ensure that all alcohol based hand rub (ABHR) in the home is not expired.
3. The IPAC Lead is to conduct an audit of all resident rooms and common areas to ensure that the ABHR is not expired and implement corrective action for any deficiencies found.
4. All audits completed are to be documented, the record kept, and immediately made available to the inspector.

Grounds
The licensee has failed to ensure that the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective: April 2024 issued by the Ministry of Health was followed in the home. In accordance with these recommendations the licensee was required to ensure that alcohol-based hand rubs (ABHR) must not be expired.

During the inspection, ABHR was observed to be expired on the first floor, in the Chamber of Commerce conference room, and on a resident home area.

Review of the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective: April 2024, noted that "ABHR are the first choice for hand hygiene when hands are NOT visibly soiled" and "ABHR must not be expired."

The General Manager (GM) acknowledged that the home was using expired ABHR and that they would do a complete sweep of the home to remove all expired ABHR immediately.

There was risk to the residents and staff of potential transmission of micro-organisms when the home used expired ABHR products.

Sources: Review of Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective: April 2024, observations in the home, interview with GM.

This order must be complied with by December 6, 2024

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

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130 Dufferin Avenue, 4th Floor
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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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