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

Public Report

Report Issue Date: February 11, 2025

Inspection Number: 2024-1474-0007

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 dates: January 7 - 10, 14 - 17, 2025
The inspection occurred offsite on the following dates: January 13, 2025 and February 4, 2025
The following intakes were inspected:

- Intake: #00128404 - Critical incident (CI) #3046-000076-24 - related to prevention of abuse and neglect, continence care, and skin and wound care.
- Intake: #00130789 - follow-up #01 - related to infection prevention and control.
- Intake: #00134593 - CI #3046-000096-24 - related to falls prevention and management.
- Intake: #00134963 - Complaint related to alleged abuse/neglect, skin and wound care, continence care.
- Intake: #00135896 - Complaint related to resident care and supportive services/transfers.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2024-1474-0004 related to O. Reg. 246/22, s. 102 (2) (b)

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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 a resident plan of care was provided as specified. It was observed by the inspector that a staff used a care product on the resident, despite the care plan indicating that product should not be used.

Sources: Observation, clinical records and interviews with staff.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

The licensee failed to ensure that staff consistently monitor, assess, and address the resident's needs. Staff failed to complete essential assessments when the resident experienced pain. Additionally, the licensee failed to ensure that staff responded promptly to the resident call bell. This delay in addressing the resident's needs compromised the timeliness of care and created unnecessary distress for the resident. Furthermore, there were significant delays in communicating lab results. Preliminary lab results indicating a positive result was not promptly communicated, which hindered timely decision-making and delayed appropriate treatment.

Sources: Clinical records for the resident, interview with staff.

WRITTEN NOTIFICATION: Conditions of licence

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2024_1474_0004 issued on October 30, 2024, with a compliance due date of December 20, 2024 to O. Reg. 246/22 s. 102 (2) (b).

The following components of the order were not complied:

A) All direct care staff who may work on Kingsville 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 Kingsville 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.

The licensee failed to ensure that 30 out of the 86 staff members assigned to the Kingsville neighborhood from October 31, 2024, to January 7, 2025, including those transferring from other neighborhoods, completed the required education related to hand hygiene for residents. Additionally, the licensee failed to ensure that all residents from all units, and their families, were adequately informed and educated

about the home's hand hygiene program. Only the residents from the Kingsville unit were provided with information and education regarding the home's hand hygiene program and only 193 family members were emailed educational materials and information pertaining to the home's hand hygiene program, leaving at least 63 family members having not received any information. Lastly, while audits were conducted as outlined in Section C of the order, the licensee failed to conduct the daily hand hygiene audits after all direct care staff completed their hand hygiene education.

Sources: Training records of staff who worked on the Kingsville neighborhood since October 31, 2024, email correspondence related to education and information provided to the families of resident's of the home, and interviews with staff.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
O. Reg. 246/22 - s. 102 (2) (b)

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 2.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.

The licensee failed to ensure that weekly skin assessments were conducted as ordered for a resident, which were necessary to properly monitor their condition.

Sources: Clinical records for the resident and interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that registered staff completed a skin assessment for a resident when altered skin integrity was observed. A review of the resident's progress notes indicated that the resident had altered skin integrity. However, there was no documentation of a clinically appropriate assessment instrument being used to evaluate or monitor the condition.

Sources: Clinical records for the resident a staff interview.

WRITTEN NOTIFICATION: Maintenance services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

The licensee failed to ensure that their developed procedures were implemented, to ensure that mechanical lifts are kept in good repair, when the pre-start up

inspection checklist was not completed for a lift on January 1-9, 2025, or for a different lift on January 3 and 6, 2025. The home's procedure is to complete a daily start up inspection checklist on each mechanical lift during the day shift to ensure they are in safe working order.

Sources: Pre Start Up Inspection Policy (Tab 03-13 of the home's Occupational Health and Safety Policy Manual, last reviewed April, 9, 2024), and Start Up Inspection checklists for January 2025.

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall,
1. Create a written plan to have all required staff attain the annual retraining on correct use of equipment, specifically mechanical lifts, in 2025
2. Develop and implement a system to communicate reminders to staff in the home regarding following the home's safe lifts and transfers policies and procedures by the compliance due date.
3. Conduct an anonymous survey of home staff to identify if staff are completing mechanical lift transfers independently and if yes, why. Keep a record of the survey, date completed, and the results.
4. Use the results from the survey conducted in #3 to develop an action plan that addresses any concerns identified, keep a record of the developed action plan, who

was part of the development, and the date it was completed.

Grounds

The licensee failed to ensure that a staff used safe transferring techniques when assisting a resident. A staff attempted to transfer a resident alone, but the home's policy and the resident's care plan indicated the resident required two staff for transfers. The resident fell during the transfer attempt.

Sources: Resident progress notes, care plan, and the home's investigation notes.

This order must be complied with by April 25, 2025

COMPLIANCE ORDER CO #002 Training

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Complete an audit to identify all staff that did not complete annual retraining in 2024 on safe and correct use of equipment, specifically mechanical lifts. Staff identified by the audit, that have already completed the training in 2025 to date, can be removed from the list.
2. Retain a record of the audit performed in #1, who completed it, and the results.
3. Create a written plan to complete the required retraining on correct use of

equipment, specifically mechanical lifts, by the compliance due date, for all staff identified in the audit completed in #1.
4. Ensure the annual retraining on correct use of equipment, specifically mechanical lifts, is completed for all those identified in the audit completed in #1 by the compliance due date.
5. Retain a record of the training provided that includes the training materials, the date of the training, who provided the training and all staff members who attended.

Grounds

The licensee failed to ensure that all required staff received annual retraining on safe and correct use of equipment, specifically mechanical lifts in 2024, as mandated in O. Reg. 246/22 s. 259 (1) 2.. In accordance with O. Reg. 246/22 s. 260 (1), this education is required annually. Staff training records for 2024, specific to annual retraining on mechanical lifts and transfers, showed that 137 staff did not have this education completed. Not ensuring all required staff completed the retraining posed a potential safety risk to residents and staff.

Sources: Interview with staff and staff training records.

This order must be complied with by April 25, 2025

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.