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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
centralwestdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 29, 2022

Inspection Number: 2022-1476-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village at University Gates, Waterloo

Lead Inspector	**Inspector Digital Signature**
Janis Shkilnyk (706119)	Janis M Shkilnyk Digitally signed by Janis M Shkilnyk Date: 2023.01.12 13:16:45 -05'00'

Additional Inspector(s)
Kristen Owen (741123)
Kaitlyn Puklicz (000685) was also present during this inspection

INSPECTION SUMMARY

The Inspection occurred on the following date(s): December 13, 14, 16, 19-21, 2022, offsite: December 15, 2022

The following intake(s) were inspected:

Log # 00011059, Log # 00011293 related to an allegation of staff to resident abuse.

Log # 00011060 which was a follow up to the compliance order #001 from inspection # 2002_1476_0001 related to infection control.

Log # 00012732 related to nutrition and hydration concerns for a resident.

Log # 00014879 and Log # 00015505 related to an unexpected death of a resident.

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

Prevention of Abuse and Neglect
Food, Nutrition and Hydration
Infection Prevention and Control
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that staff carried out every operational or policy directive that applied to the long-term care home when staff were observed not following the recommended guidelines for Personal Protective Equipment (PPE) use when in an outbreak area of the home.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, the licensee was required to ensure that the PPE requirements as set out in the COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities (PDF), or as amended, were followed. As per COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities, version 1.0, June 2022, all staff and essential visitors/caregivers providing direct care to or interacting within 2 metres of a resident with suspect or confirmed COVID-19 or in an outbreak area should wear eye protection (goggles, face shield, or safety glasses with side protection), gown, gloves, and a fit-tested, seal-checked N95 respirator (or approved equivalent) as appropriate PPE.

Rationale and Summary

A confirmed disease outbreak was declared on one resident home area in the home.

A staff was observed in the outbreak resident home area wearing only a surgical mask and did not have any eye protection on. Two other staff in the outbreak area were observed wearing only surgical masks and no eye protection.

A staff member was observed on the outbreak area wearing two surgical masks and no eye protection. The staff member stated they have difficulty wearing the N95 mask and face shield.

There was signage posted at the entrance of outbreak resident home area that stated team members must wear an N95 mask and face shield at all times. The Infection Prevention and Control (IPAC) Lead said all staff were required to wear an N95 mask and face shield while on the unit, even if they are not providing direct care to a suspected or disease outbreak case.

Staff members not wearing eye protection or N95 masks on a confirmed outbreak area in the home, may have resulted in an increased risk of transmission of the infectious disease throughout the home.

Sources: Interview with staff, resident home area observations, Ministers Directive: COVID-19 Response Measures for Long Term Care Homes, effective August 30, 2022, COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities, version 1.0, June 10, 2022.

[741123]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (2) (e)

The licensee has failed to comply with procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents related to allegations of staff to resident abuse.

In accordance with O. Reg. 246/22 s. 11. (1) (b) the staff did not comply with the licensee's policy, investigation process for suspected abuse of a resident by team member, volunteer or visitor, tab 04-06B. The policy stated the alleged offender would be escorted off the neighbourhood and not to re-enter the neighbourhood. The alleged offender, if a team member would be placed on administrative leave with pay, pending review. The charge nurse or leadership team member was to begin an investigation immediately and complete abuse algorithm to identify action required. An internal incident form was to be initiated. The charge nurse or designate was to notify the resident's substitute decision-maker, if any, and any other person specified by the resident within 12 hours upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident. Any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal

offence was to be reported to the appropriate police service by the charge nurse or designate immediately.

Specifically, the staff did not comply with the licensee's policy, investigative process for suspected abuse of a resident by a team member, volunteer or visitor, tab 04-06B which stated the team member should not be on the neighborhood once an allegation of resident abuse was identified towards that team member. The resident's power of attorney was to be notified within 12 hours upon becoming aware of an allegation of resident abuse towards that resident. The police services were to be notified immediately of any alleged, suspected or witnessed incident of resident abuse that may constitute a criminal offence.

Rationale and Summary

The home submitted a critical incident to the Director related to allegations of staff to resident abuse.

The home's investigation related to the incident was initiated. Review of the home's investigative notes documented the resident's Powers of Attorney (POA's) were not notified within 12 hours of the allegations of resident abuse towards them. The police were not notified immediately of the allegation of staff to resident abuse. No internal incident form was found for the residents in their clinical records related to the allegation of staff to resident abuse.

A staff member said they had reported the allegation of abuse by a staff member towards residents to a manager in the morning of the alleged incident.

The General Manager stated that the police were not contacted immediately, that the staff member accused of the allegation of resident abuse, completed their shift that day and the residents involved did not have an incident form completed related to the alleged allegation of resident abuse towards them.

The Neighboorhood Coordinator stated that the POA's for the residents were not notified of the allegations of abuse immediately.

The home's failure to follow their investigative process for suspected abuse of a resident by a team member, volunteer or visitor, tab 04-06B policy, could have led to potential risk for residents by not investigating all aspects of the alleged allegations of abuse towards the residents.

Sources:

Interviews with staff, residents' clinical records, investigative notes, critical incident summary, policy-investigation process for suspected abuse of a resident by team member, volunteer or visitor, tab 04-06B

[706119]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that an allegation of abuse related to two residents was reported to the Director immediately.

The home received an allegation of abuse. They submitted a critical incident systems (CIS) report to the Director two days later.

The General Manager confirmed that the critical incident should have been reported immediately.

The potential risk of harm to the residents may have occurred as the Director was unable to take action, if required.

Sources:

Critical incident summary, investigative notes, interview with General Manager.

[706119]

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

The licensee failed to ensure that residents rights were fully respected and promoted when a resident was not afforded privacy.

Rationale and Summary

A staff member took a picture of a resident using their personal device.

The home's records indicated that the staff member had violated the resident's bill of rights, resident privacy, and demonstrated disregard for their dignity.

This breach of privacy caused potential risk that the photograph could be shared more broadly.

Sources:

Interview with registered staff, investigative notes, letter of statement from staff member.

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