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

Original Public Report

Report Issue Date: June 12, 2023

Inspection Number: 2023-1476-0005

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**
Nuzhat Uddin (532)	Nuzhat J Uddin Digitally signed by Nuzhat J Uddin Date: 2023.06.12 12:49:05 -04'00'

Additional Inspector(s)
Diane Schilling (000736)
Megan Brodhagen (000738)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 25-26, 30-31, 2023, and June 1-2 and 5-7, 2023.

The following intake(s) were inspected:
- Intake: #00021436 was related to improper transfer
- Intake: #00021645 and Intake: #00087508 was related to fall prevention and management
- Intake: #00022754 and Intake: #00021979 and Intake: #00022818 was related to prevention of abuse and neglect
- Intake: #00086670 - Follow-up #: 1 - FLTCA, 2021 - s. 24 (1)

The following intake was completed in this inspection: Intake #00021645 was related to fall prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1476-0004 related to FLTCA, 2021, s. 24 (1) inspected by Nuzhat Uddin (532)

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting the residents.

A) Two Personal Support Workers (PSW) were transferring a resident using unsafe transferring and positioning devices and techniques and the resident sustained injuries.

Failure to use safe transferring and positioning techniques when assisting a resident placed the resident at risk of harm and pain.

Sources: Record review i.e., progress notes, plan of care, pain and skin assessment, investigation notes, interview with resident, PSW and the ADOC.

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B) A resident had an unwitnessed fall in their room.

The home's "Fall Prevention & Management Program Policy" directed Registered Nursing Team Members to move the resident and assist to chair or bed using proper lift and transfer procedures. If a resident was unable to assist to stand (independent or 1-person transfer status), then the total mechanical lift will be used for safety.

A Registered Nurse (RN) and two Personal Support Workers (PSW) did not use safe transferring and positioning devices when assisting the resident, which resulted in the resident being negatively impacted.

The Director of Program for Active Living (PAL) acknowledged that staff members should have used safe transferring and positioning devices and techniques when assisting the resident.

The resident was placed at risk of harm when they were improperly transferred post-fall which resulted in increased pain to the resident.

Sources: Fall Prevention & Management Program Policy (no date), Resident's: plan of care, progress notes, fall incident notes, pain assessments, and Interviews with RN and Director of Program for Active Living and other staff.

[000738]