Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 12, 2016	2016_262523_0016	007195-16	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

THE VILLAGE OF GLENDALE CROSSING
3030 Singleton Avenue LONDON ON N6L 0B6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ALI NASSER (523), AMIE GIBBS-WARD (630), DEBORA SAVILLE (192), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 14, 15, 16, 17, 18, 21, 22, 23, 24, 30 & 31 2016

The following inspections were completed concurrently during the RQI:
Follow Up Log # 036511-15 (compliance date December 30, 2015) related to personal support services.
Follow Up Log # 036517-15 (compliance date January 15, 2016) related to updating

plan of care.
Follow Up Log # 036513-15 (compliance date February 29, 2016) related to production sheets for snack menus.
Follow Up Log # 036516-15 (compliance date February 15, 2016) related to policies of the home not being complied with.
Follow Up Log # 028809-15 (compliance date November 27, 2015) related to polices of the home not complied with and safe storage of medications.
Follow Up Log # 036514-15 (compliance date January 15, 2016) related to documenting resident's response to medications.
Complaint Log # 036499-15 (IL-42288-LO) related to resident's responsive behaviours and resident to resident abuse.
Complaint Log # 029180-15 (IL-41206-LO) related to multiple care concerns.
Complaint Log # 028828-15 (IL-41177-LO) related to a resident's responsive behaviours and the duty to protect residents.
Critical Incident Log # 027460-15 (CI # 2979-000038-15) related to a resident's responsive behaviours and resident to resident abuse.
Critical Incident Log # 034811-15 (CI # 2979-000061-15) related to a resident's responsive behaviours, physical altercations between residents and duty to protect residents.
Critical Incident Log # 029714-15 (CI # 2979-000049-15/2979-000053-15) related to a resident's responsive behaviours, altercations between residents, duty to protect and plan of care.
Critical Incident Log # 028150-15 (CI # 2979-000040-15) related to providing a safe and secure environment to a resident.
Critical Incident Log # 007875-16 (CI # 2979-000012-16) related to a resident's responsive behaviours, resident to resident abuse and duty to protect residents.
Critical Incident Log # 007097-16 (CI # 2979-000008-16) related to falls.

During the course of the inspection, the inspector(s) spoke with the two General Managers, Director of Nursing, Assistant Director of Nursing, Director of Environmental Services, Director of Food Services, Director of Recreation, a Physiotherapist, a Registered Dietitian, a Kinesiologist, a housekeeping staff, a Ward Clerk, two Recreation Aides, three Dietary Aides, three Neighbourhood Coordinators, , 15 Registered Staff, 31 Personal Support Workers, Family Council President, Resident Council President, eight family members and over 40 residents.

The inspector(s) also conducted a tour of the home and made observations of

residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry of Health and Long-Term Care information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **28 WN(s)**
- **13 VPC(s)**
- **16 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 72. (2)	CO #008	2015_183128_0023	630

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that was secure and locked, that protected the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates).

A) Observations during the inspection revealed that a medication room door was propped open, the medication room was unattended, and keys for the medication cart were left on the cart in the room. On another occasion a medication cart in the hallway was left unlocked and unattended, and no staff were visible.
The Director of Nursing #102 confirmed that the door should have been closed and locked and the medication room locked when was unattended.

B) Observation during this inspection revealed that in the medication room were expired drugs in a cupboard and on top of the treatment cart.

C) Observations during stage one of this Resident Quality Inspection revealed that prescription ointments and creams were left in the resident's bathrooms and on resident's bedside tables

The licensee failed to ensure that drugs were stored in an area or a medication cart that was secured and locked, and that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates). [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Observation during this inspection revealed that a medication cart was observed in the medication room to be unlocked. When the medication drawer was opened, the narcotic bin was noted to be unlocked and the Inspector could readily open the bin.

The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Clinical record review, resident and staff interviews revealed that resident #002's plan of care was not based on his/her preference in regards to oral care.

The licensee failed to ensure that the plan of care for resident #002 included the resident's needs and preferences in regards to oral care. [s. 6. (2)]

2. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Clinical record and evidence review revealed that the care set out in the plan of care for resident #003 was not provided as specified in the plan.

The licensee failed to ensure that resident #003 received the care specified in the plan of care.[s. 6. (7)]

3. The licensee has failed to ensure that staff and others who provide direct care to the resident kept aware of the contents of the plan of care and have convenient and immediate access to it.

Clinical record review and staff interviews revealed that the plan of care for resident #080 in regards to responsive behaviours was not made available to staff. [s. 6. (8)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Clinical record review and staff interview revealed that the plan of care for resident #012 was not reviewed and revised when the resident's care needs were changed or the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

5. The licensee has a history of non-compliance with plan of care being reviewed and revised.
Clinical record review and staff interviews revealed that the home did not fully implement the plan for a previous compliance order that was issued to ensure that a resident was reassessed and the plan of care reviewed and revised and to ensure the care provided to the resident was effective. [s. 6. (10) (c)]

6. The licensee has failed to ensure that if the resident was being reassessed and the plan of care being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

Clinical record review and staff interviews revealed that when resident #013 was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches had not been considered in the revision of the plan of care. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 002, 014 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
.The plan of care was based on an assessment of the resident and the resident's needs and preferences.
.The staff and others who provide direct care to the resident kept aware of the contents of the plan of care and have convenient and immediate access to it.
.The resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.
.If the resident was being reassessed and the plan of care being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement.

A review of the staffing schedules and staff interview revealed that the home did not currently have sufficient registered nurses that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement. [s. 8. (3)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

A) A clinical record review, staff and resident interviews revealed that there was no documented evidence regarding how the home addressed resident #007's concerns, anxiety and fears that were expressed by resident to the staff [s. 19. (1)] (630)

B) A clinical record review revealed that the physician was not informed when resident #051 refused assessments to be initiated following an incident. [s. 19. (1)]

2. The licensee has failed to ensure that residents were protected from abuse by anyone in the home.

A) A clinical record review and staff interviews revealed that resident #052 had several documented incidents of responsive behaviors, verbal, physical and sexual abuse. Some of those incidents had resulted in injuring other residents.
After 50 days of exhibiting those behaviors the resident was assessed for responsive behaviors, but incidents continued to occur despite the assessment.
Resident #052 physically attacked other residents and staff members.

DON #102 confirmed in an interview that the home had failed to protect various residents from abuse caused by resident #052. [s. 19. (1)] (523)

B) Clinical record review and staff interviews revealed that resident #043 had demonstrated physical responsive behaviors on different residents on numerous occasions that resulted in redness, bruising and abrasions.
DON #102 confirmed in an interview there was a significant delay between the first incident involving resident #043 and the time the responsive behaviors were assessed and interventions developed. DON #102 confirmed the home had failed to protect residents from abuse by resident # 043. [s. 19. (1)] (630)

C) Clinical record review and staff interviews revealed that resident #025 had grabbed resident #024 on two different occasions causing physical harm.
Clinical record review revealed that residents were assessed and interventions stated to make sure that residents are kept in separate areas and "staff will monitor residents as best as possible"
Observations during this inspection revealed that resident #025 was unsupervised and attempted to reach out and grab inspector #192's arm.
The Neighbourhood Coordinator (NC) #115 confirmed that nothing had been done related to support for resident #024 after either of the reported incidents. The NC and Personal Expressions Resource Registered Practical Nurse (PERT RPN) #160 both

confirmed that the staff were not able to monitor these residents at all times and that there were times when the residents were in the same area unsupervised by staff. Resident #024 was not protected from abuse by resident #025. [s. 19. (1)] (213)

D) Clinical record review for resident #020 and staff interviews revealed that on several occasions resident #020 was physically aggressive against other residents resulting in injuries.
Interview with Neighbourhood Coordinator #186 confirmed that physical aggression and altercations with other residents had not been identified as a concern for resident #020, triggers and strategies related to physical aggression for resident #020 had not been identified until five months following the first incident of a physical altercation involving resident #020. This was after several incidents of physical aggression toward other residents, including two incidents of physical aggression towards resident #021. [s. 19. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that when a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

A review of Internal Incident Reports completed by staff related to incidents between different residents on various occasions revealed that staff had identified these incidents as abuse that resulted in harm/risk of harm.
These incidents were signed by the General Manager.

An interview with NC #122 revealed that the home did not report the above incidents of physical abuse that resulted in harm or risk of harm to the Director. [s. 24. (1)]

2. During stage one of this Resident Quality Inspection, resident #008 identified that a staff member had treated them roughly.
The reported incident involving resident #008 was shared with General Manager #101.
The review of the Critical Incident System identified a Critical Incident in relation to the allegation of abuse involving resident #008 had been submitted nine days after the General Manager was made aware of the incident.

The licensee failed to ensure that an allegation of abuse of a resident by the licensee or staff that resulted in harm or risk of harm was immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

A clinical record review, staff and resident interviews revealed that the staff did not comply with the home's own policies, procedures and process, specifically related to below policies:

Mechanical lifts: mechanical lift was not used when a resident was found on the floor.
Nutrition and Hydration: plan for a previous order was not completed specifically for providing education for all staff providing direct care.
Infection Prevention and Control: no list kept of residents who have certain communicable diseases, signage was not posted, no notes in care plans.
Skin and Wound Care: skin assessment not completed post hospitalization and when new skin breakdown occurred and skin assessment concern forms not completed.
Medication Administration Pass: staff not remaining with residents when administering medications.
Safety-Incident Report: incident report forms were not fully completed.
Head Injury Routine: head injury routine assessment was not initiated.
Falls Prevention and Management: post fall assessment not completed.
Documentation: treatment records not fully completed.
Sanitization/Risk Management Personal Care: personal care items unlabelled.
Personal Expression Program: DOS charting not completed per policy.

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept locked when they are not being supervised by staff.

A clinical record review and staff interviews revealed that a door leading to a non-residential area was left unsupervised while it was open. A resident was found in this non-residential area where resident had fallen and sustained an injury.

DON #102 confirmed that the home had failed to keep all doors locked when not supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

Observations during the Resident Quality Inspection revealed that some windows in the home had the tilt function that when activated opened the windows more than 15 centimetres.

The General Manager #101 and Director of Nursing #102 confirmed that the home's expectation was that every window in the home that opens to the outdoors and was accessible to residents could not be opened more than 15 centimetres. [s. 16.]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Clinical record review and staff interviews revealed that the home did not fully implement with the plan for a previous compliance order that was issued to ensure that a resident was offered a bath at a minimum twice a week, resident refusal and re-approach will be documented.

DON #102 confirmed that the home had not complied with the order. [s. 33. (1)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and (b) identifying and implementing interventions.

Clinical record reviews, staff interviews and review of Internal Incident Reports revealed that staff had identified responsive behaviours and altercations between different residents on several occasions.

DON #102 and Neighbourhood Coordinator #186 confirmed in an interview that there was a delay in identifying physical aggression and altercation between residents and a delay between the first incident of altercation between residents and the time the behaviour was assessed and interventions and strategies were developed and implemented.

DON #102 confirmed the home had failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents. [s. 54.]

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Clinical record reviews, staff, residents and family member's interviews revealed that the home did not keep a documented record of specified complaints raised by residents and/or family members.

Documentations regarding the actions and responses and final resolutions to the concerns were not completed. [s. 101. (2)]

Additional Required Actions:

CO # - 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Clinical record review and staff interviews revealed that a resident had received a medication that required an evaluation of the effectiveness of that medication. Further review revealed that there was no documentation of the resident's response to the medication and the effectiveness of that medication. [s. 134. (a)]

Additional Required Actions:

CO # - 012 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program; O. Reg. 79/10, s. 229 (2).
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).
(c) that the local medical officer of health is invited to the meetings; O. Reg. 79/10, s. 229 (2).
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an interdisciplinary team approach in the co-ordination and implementation of the program; that the interdisciplinary team that co-ordinates and implements the program met at least quarterly; that the local medical officer of health was invited to the meetings; that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and that a written record was kept relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Record review and staff interviews revealed that the home does not have an interdisciplinary Infection Prevention and Control program (IPAC), the IPAC did not meet quarterly, and there was no documentation of a full IPAC program evaluation including an evaluation of the program goals and strategies or any hand hygiene audits completed. [s. 229. (2)]

2. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A) During the RQI RN #150 was observed dropping two pills on the floor, pick them up off the floor and then gave them to the resident. Interview with RN #150 confirmed that she had dropped the pills on the floor and then picked them up off the floor and gave them to resident #044 to swallow.

Interview with General Manager #101 and Director of Nursing #102 that it was the expectation of the home that all staff would participate in the implementation of the infection prevention control including not giving residents medications that touch the floor.

B) Observations during the RQI revealed that the dining room tables on a specified neighbourhood set with cutlery and mugs and these were uncovered. Residents with cognitive impairment were observed wandering in the dining room at the time and touching multiple surfaces. The dining room did not have doors or gates to keep residents from entering the room.
Interview with Director of Food Services #147 identified that the process in the home was that tables were set mid-morning for the lunch, around 1600 for supper and then in the

evening for the next day breakfast. She confirmed the practice in the home was to not cover the utensils or the cups and that some neighbourhood dining room do not have doors and residents wander.

She confirmed this was an infection prevention and control issue and that it was the expectation in the home that tables would be set in a manner to minimize risk of transmission of infections. [s. 229. (4)]

3. The licensee has failed to ensure that the following immunization and screening measures are in place:

Record review and interview with the Assistant Director of Nursing Care #117 confirmed that the home has not been compliant in monitoring the need for or providing immunizations for residents when required for pneumococcus, tetanus/diphtheria, influenza or in tuberculosis screening. [s. 229. (10)]

Additional Required Actions:

CO # - 013, 015, 016 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be properly cared for in a manner consistent with his or her needs was fully respected and promoted.

A clinical record review and staff interview revealed that a Registered Staff member had initiated a treatment that was not within the home's policy, procedure or best practice guidelines.

An interview with the wound care program lead #149 confirmed that this was an improper treatment and care for the resident. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's right to be properly cared for in a manner consistent with his or her needs was fully respected and promoted, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system be easily accessed and used by residents at all times.

A) Observations during the RQI revealed that a call bell was not available for one resident in a room that he/she recently moved to.
An interview with DON #102 revealed that a resident had moved a new room where only one call bell was available at one bed side.

B) Observation and resident interview revealed that resident was unable to reach the call bell when he/she sits in their chair. Resident expressed concerns to the home about being unable to access and uses the call bell.

This was confirmed with the DON #102 who also confirmed that it was the home's expectation that the resident-staff communication and response system be easily accessed and used by residents at all times. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident-staff communication and response system be easily accessed and used by residents at all times, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that was reported was immediately investigated.

Record review, staff and resident interviews revealed that an alleged incident of staff to resident abuse had occurred. This incident was reported to the General Manger #101 who reported that an investigation would be initiated into the allegation.

An interview with Neighborhood Coordinator (NC) #115 nine days after the General Manager (GM) #101 was made aware of the alleged abuse that GM #101 had completed an interview of the resident but no further action had been taken in relation to the allegation of abuse.
NC #115 confirmed that the staff member accused had not been interviewed and had continued to work on the neighborhood, providing care to resident. NC #115 confirmed that no other steps in the investigation of the allegation of abuse had been completed.

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported is immediately investigated. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that was reported was immediately investigated, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation, that there was a written description of the program that includes its goals and objectives, the program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and the licensee shall keep a written record relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A) A review of the skin and wound care program and an interview with the wound care management program lead #149 revealed that the wound management program was not an interdisciplinary team, there was no written description of the program that includes its goals and objectives and there was no written record for an annual evaluation that was completed for the program. [s. 30. (1)] (523)

B) A review of the home's continence care and bowel management program and an interview with Registered Practical Nurse #149 confirmed that there are no goals and objectives for the continence program. [s. 30. (1) 1.]

2. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Clinical record review and staff interviews revealed that resident #012 was identified to be at risk in relation to decreased bed mobility and altered skin integrity; further review revealed that interventions related to bed mobility were not fully documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation, that there was a written description of the program that includes its goals and objectives, the program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and the licensee shall keep a written record relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, and
to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) A clinical record review for resident #011 revealed that there was no skin and wound assessment completed for a newly identified wound.

An interview with the skin and wound management program lead #149 confirmed that the expectation was that a skin assessment would be initiated for the resident when a new tear, wound or ulcer had been identified. [s. 50. (2) (b) (i)](523)

B) Clinical record review for resident #012 and interview with RPN #149 and #153 confirmed that no Wound Assessment Tool was completed in relation to the altered skin integrity identified for resident #012.

The licensee failed to ensure that resident #012 received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff.

Clinical record review for resident #012 revealed that there was no weekly wound assessments related to the identified areas of altered skin integrity.
The licensee failed to ensure that resident #012, who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity including skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care and bowel management program included an annual resident satisfaction evaluation of the continence care products in consultation with residents, substitute decision-makers and direct care staff with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated.

An interview with Neighborhood Coordinator #115 confirmed that no satisfaction survey had been completed with substitute decision-makers in relation to continence care products. [s. 51. (1) 5.]

2. The licensee has failed to ensure that the resident who is unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Clinical review, staff and resident interviews revealed that resident #008 required the assistance of staff to transfer to toilet.
Further interviews revealed that at the time the resident needed to use the bathroom the staff were busy and were not able to assist the resident to the bathroom resulting in incontinence at least daily. The resident identified that they would like to have staff assist them to the bathroom at regularly scheduled times.

The licensee failed to ensure that resident #008, who is unable to toilet independently, received assistance from staff to manage and maintain continence. [s. 51. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that :
The continence care and bowel management program included an annual resident satisfaction evaluation of the continence care products in consultation with residents, substitute decision-makers and direct care staff with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated.
The resident who is unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) 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. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Family council advice related to concerns or recommendations.

Record review and interviews revealed that the home had not responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

An interview and record review with Director of Recreation #145 confirmed there was no documented evidence of written responses from the General Manager or other staff in the home regarding concerns that were raised during the meetings. She confirmed it was the expectation of the home to have response letters to concerns in the resident and family councils within 10 days. [s. 60. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to respond in writing within 10 days of receiving Family council advice related to concerns or recommendations, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (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. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that that all staff received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

A review of the education records from February 1, 2015, to March 21, 2016, revealed that 86 per cent of the staff had received training.

An interview with NC / Educator #122 confirmed that 86 per cent of the current staff had received their training on prevention of Abuse and Neglect.

NC / Educator #122 confirmed that the expectation was to have all staff retrained annually. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that all staff receive retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

Observations and interview with Neighborhood Coordinator #115 confirmed that they do not dispense, prescribe or administer medication and that they did have access to the area where immunization vaccines were stored. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Clinical record review and staff interviews revealed that resident #033 did not receive a certain medication in accordance with the direction for use specified by the prescriber.

Interview with Director of Nursing #102 confirmed that resident #033 was not provided a certain medication in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any controlled substance that was to be destroyed and disposed of should be stored in a double-locked storage area within the home until the destruction and disposal occurred.

Observation of the cabinet used to store narcotics for destruction, located in the Director of Nursing's (DON) office identified that only one lock was used for the narcotic cabinet and it was observed that the key to the cabinet was kept in an unlocked drawer in the DON's desk.

During the course of the inspection the DON's office was observed on multiple occasions to be left with the door unlocked and the office unattended.

Interview with DON #102 confirmed that other staff in the home, including the Environmental Manager had access to their office. It was also noted in the presence of the DON that the cabinet used to store the controlled substances could be easily moved side to side and it was confirmed by the DON that the cabinet could be lifted off support attaching it to the wall.

The licensee failed to ensure that any controlled substance that was to be destroyed and disposed of should be stored in a double-locked storage area within the home until the destruction and disposal occur. [s. 136. (2) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home until the destruction and disposal occurs, to be implemented voluntarily.

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

A review of the Internal Incident Report form revealed that resident #001 was the recipient of physical abuse by another resident.

A review of the Internal Incident Report forms revealed that there were 2 forms of resident #054 physical aggressions towards a staff member.

A clinical record review for residents #001 & #054 revealed that there was no documentation in the clinical records indicating that those incidents occurred.

This was confirmed by NC #122, who confirmed in an interview the expectations would be that staff document in the progress notes of the clinical records any similar events involving the residents and ensure the records were kept up to date. [s. 231. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's written record was kept up to date at all times, to be implemented voluntarily.

WN #26: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forward it to the Director.

An Interview NC #106 revealed that she had received two written complaints from a family member of resident #042.

An interview with NC #106 confirmed that she had not forwarded this written complaint to the Director. Interview with DON #102 on March 30, 2016, identified she was also aware of the written complaint regarding resident #042 and had no documented evidence that she had forwarded the complaint to the Director.
DON #102 acknowledged that it was the expectation in the home that the Director would be notified immediately of written concerns regarding alleged abuse of a resident. [s. 22. (1)]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan included a back-up plan for nursing and personal care staff that addressed situations when staff could not come to work.

An interview with Director of Nursing #102 confirmed that the written staffing plan for the home did not include a back-up plan for nursing and personal care staff that addressed situations when staff could not come to work. A "Call in procedure" was provided as the back-up plan but failed to address situations when staff could not come to work and how resident care needs would be addressed.

The DON #102 was able to describe a process whereby the float may be pulled to assist on a home area when a call in could not be replaced. There was no documentation to support this process.

The licensee failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addressed situations when staff could not come to work. [s. 31. (3)]

2. The licensee has failed to ensure that there was a written record of each annual evaluation of the staffing plan including the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of the annual evaluation of the staffing plan, confirmed by the Director of Nursing #102, failed to identify the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 31. (4)]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that that the homes written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

Review of the home's policy "Prevention of Abuse in Long-Term Care", tab 04-06, dated November 2013, failed to identify interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents.

Interview with the Director of Nursing (DON) #102 identified that when the accused was a staff member of the home, the team member was removed from the home area, initial interviews are conducted in relation to the investigation and the staff member would be sent home until the investigation had been completed. DOC #102 confirmed that the

policy failed to address interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents.

Interview with Neighborhood Coordinator #115 confirmed that the expectation when there was an allegation of abuse or neglect involving a staff member would result in the staff member being removed from the neighborhood, initial interviews would be conducted and the staff member would be sent home, pending results of the investigation into allegations.

Resident #008 identified during stage one of this Resident Quality Inspection that a staff member had treated them roughly. Resident #008 was able to provide the name of the staff member that had treated them roughly causing pain and anxiety. Resident #008 identified that their concerns had not previously been reported to the home. Inspector #192 reported the incident to General Manager (GM) #101. Neighborhood Coordinator #115 confirmed that no action had been taken with regard to protecting resident #008 from the identified staff member and that the staff member had worked on the home area seven of the nine days since the incident had been reported to GM #101.

Interview with resident #008 identified that the staff member continued to be rough when providing care and rushed the resident during care.

The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents. [s. 96. (b)]

Issued on this 26th day of May, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALI NASSER (523), AMIE GIBBS-WARD (630), DEBORA SAVILLE (192), RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2016_262523_0016
Log No. / Registre no:	007195-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 12, 2016
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF GLENDALE CROSSING 3030 Singleton Avenue, LONDON, ON, N6L-0B6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MICHELLE VERMEEREN

To Schlegel Villages Inc, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_217137_0040, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee shall ensure that:
The medication carts and rooms are kept locked when unattended.
All expired medications should be stored separately and disposed of.
All medications should be stored in a medication area or cart.
All Narcotic substances are double locked.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that was secure and locked, that protected the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates).

A) Observations during the inspection revealed that a medication room door was propped open, the medication room was unattended, and keys for the

medication cart were left on the cart in the room. On another occasion a medication cart in the hallway was left unlocked and unattended, and no staff were visible.
The Director of Nursing #102 confirmed that the door should have been closed and locked and the medication room locked when was unattended.

B) Observation during this inspection revealed that in the medication room were expired drugs in a cupboard and on top of the treatment cart.

C) Observations during stage one of this Resident Quality Inspection revealed that prescription ointments and creams were left in the resident's bathrooms and on resident's bedside tables

The licensee failed to ensure that drugs were stored in an area or a medication cart that was secured and locked, and that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates). [s. 129. (1) (a)] (192)

2. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Observation during this inspection revealed that a medication cart was observed in the medication room to be unlocked. When the medication drawer was opened, the narcotic bin was noted to be unlocked and the Inspector could readily open the bin.

The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]

This non-compliance was previously issued as a Written Notification and a Compliance Order under O. Reg. 79/10, s.129 on September 9, 2015, inspection # 2015_217137_0040 and a compliance date of November 27, 2015.

During this inspection the licensee was found to have not met compliance with the above compliance order. (192)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_183128_0023, CO #006;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that resident #003's responsive behaviours are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.
The licensee shall ensure that the plan for compliance that was submitted by the home in response to compliance order issued on December 18, 2015, under log # 031635-15 and inspection # 2015_183128_0023 with a compliance order date of January 15, 2016, is fully implemented specifically but not limited to the following:
The completion of the ABC charting by team members when responsive behaviors are exhibited by the resident.
Review of the plan of care with all team members and anytime time there is a revision.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Clinical record review, resident and staff interviews revealed that resident #002's plan of care was not based on his/her preference in regards to oral care.

The licensee failed to ensure that the plan of care for resident #002 included the resident's needs and preferences in regards to oral care. [s. 6. (2)]

2. The licensee has failed to ensure that staff and others who provide direct care to the resident kept aware of the contents of the plan of care and have convenient and immediate access to it.

Clinical record review and staff interviews revealed that the plan of care for resident #080 in regards to responsive behaviours was not made available to staff. [s. 6. (8)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Clinical record review and staff interview revealed that the plan of care for resident #012 was not reviewed and revised when the resident's care needs were changed or the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

4. The licensee has a history of non-compliance with plan of care being reviewed and revised.
Clinical record review and staff interviews revealed that the home did not fully implement the plan for a previous compliance order that was issued to ensure that a resident was reassessed and the plan of care reviewed and revised and to ensure the care provided to the resident was effective. [s. 6. (10) (c)]

5. The licensee has failed to ensure that if the resident was being reassessed and the plan of care being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

Clinical record review and staff interviews revealed that when resident #013 was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches had not been considered in the revision of the plan of care. [s. 6. (11) (b)]

This non-compliance was previously issued as a Written Notification on March 4, 2013, inspection #2013_185112_0019.

This non-compliance was previously issued as a Written Notification and a Compliance Order on December 18, 2015, inspection # 2015_183128_0023 with a compliance date of January 15, 2016.

During this inspection the licensee was found to have not met compliance with the above compliance order. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2016

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present at all times.

Grounds / Motifs :

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement.

A review of the staffing schedules and staff interview revealed that the home did not currently have sufficient registered nurses that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement. [s. 8. (3)]

During this inspection this non-compliance was found to have a severity level of minimal harm/risk or potential for actual harm/risk, a scope that affects the majority of the residents and an unrelated compliance history. (192)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that the home completes a review of the process of identifying abuse and neglect, altercations between residents that result in abuse and residents that are at risk. This review should be documented with action and education plans.

The licensee shall implement strategies to protect residents from abuse and neglect by anyone. These strategies should be care planned for both residents who exhibit behaviours as well as residents who are at risk of harm by residents with behaviours.

The licensee shall ensure that all staff in the home receive education and training on prevention of abuse and neglect and particularly on the actions, plans and strategies implemented in the home as required above.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone in the home.

A) A clinical record review and staff interviews revealed that resident #052 had several documented incidents of responsive behaviors, verbal, physical and sexual abuse. Some of those incidents had resulted in injuring other residents. After 50 days of exhibiting those behaviors the resident was assessed for responsive behaviors, but incidents continued to occur despite the assessment. Resident #052 physically attacked other residents and staff members.
DON #102 confirmed in an interview that the home had failed to protect various residents from abuse caused by resident #052. [s. 19. (1)] (523)

B) Clinical record review and staff interviews revealed that resident #043 had demonstrated physical responsive behaviors on different residents on numerous occasions that resulted in redness, bruising and abrasions.
DON #102 confirmed in an interview there was a significant delay between the first incident involving resident #043 and the time the responsive behaviors were assessed and interventions developed. DON #102 confirmed the home had failed to protect residents from abuse by resident # 043. [s. 19. (1)] (630)

C) Clinical record review and staff interviews revealed that resident #025 had grabbed resident #024 on two different occasions causing physical harm.
Clinical record review revealed that residents were assessed and interventions stated to make sure that residents are kept in separate areas and "staff will monitor residents as best as possible"
Observations during this inspection revealed that resident #025 was unsupervised and attempted to reach out and grab inspector #192's arm.

The Neighbourhood Coordinator (NC) #115 confirmed that nothing had been done related to support for resident #024 after either of the reported incidents.
The NC and Personal Expressions Resource Registered Practical Nurse (PERT RPN) #160 both confirmed that the staff were not able to monitor these residents at all times and that there were times when the residents were in the same area unsupervised by staff.
Resident #024 was not protected from abuse by resident #025. [s. 19. (1)] (213)

D) Clinical record review for resident #020 and staff interviews revealed that on several occasions resident #020 was physically aggressive against other residents resulting in injuries.
Interview with Neighbourhood Coordinator #186 confirmed that physical aggression and altercations with other residents had not been identified as a concern for resident #020, triggers and strategies related to physical aggression for resident #020 had not been identified until five months following the first incident of a physical altercation involving resident #020. This was after several incidents of physical aggression toward other residents, including two incidents of physical aggression towards resident #021. [s. 19. (1)] (213)

2. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

A) A clinical record review, staff and resident interviews revealed that there was

no documented evidence regarding how the home addressed resident #007's concerns, anxiety and fears that were expressed by resident to the staff [s. 19. (1)] (630)

B) A clinical record review revealed that the physician was not informed when resident #051 refused assessments to be initiated following an incident. [s. 19. (1)]

This non-compliance was previously issued as a Written Notification and a Compliance Order under LTCHA 2007 S.O. 2007 c.8, s. 19 on October 28, 2014, and was complied with.

This non-compliance was previously issued as a Written Notification and a Voluntary Plan of Correction under LTCHA 2007 S.O. 2007 c.8, s. 19 on October 6, 2015.

During this inspection this non-compliance was found to have a severity level of an actual harm/risk to residents, this non-compliance was widespread and the home had an ongoing non-compliance in this area. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall ensure that an allegation of abuse of a resident by anyone that resulted in harm or risk of harm is immediately reported to the Director.

Grounds / Motifs :

1. The Licensee has failed to ensure that when a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

A review of Internal Incident Reports completed by staff related to incidents between different residents on various occasions revealed that staff had identified these incidents as abuse that resulted in harm/risk of harm.
These incidents were signed by the General Manager.

An interview with NC #122 revealed that the home did not report the above incidents of physical abuse that resulted in harm or risk of harm to the Director. [s. 24. (1)]

2. During stage one of this Resident Quality Inspection, resident #008 identified that a staff member had treated them roughly.
The reported incident involving resident #008 was shared with General Manager #101.
The review of the Critical Incident System identified a Critical Incident in relation to the allegation of abuse involving resident #008 had been submitted nine days after the General Manager was made aware of the incident.

The licensee failed to ensure that an allegation of abuse of a resident by the licensee or staff that resulted in harm or risk of harm was immediately reported to the Director. [s. 24. (1)]

This non-compliance was previously issued as a Written Notification and a Voluntary Plan of Correction under s. 24 on October 6, 2015.

During this inspection this non-compliance was found to have a severity level of a minimal harm/risk or potential for actual harm/risk to residents, this noncompliance was found to be a pattern in the home and it was previously issued. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

Order # / Ordre no : 006

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant:
2015_217137_0040, CO #001;
2015_183128_0023, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the following home's policies and procedures are complied with:
Mechanical Lifts
Nutrition and Hydration
Infection Prevention and Control
Skin and Wound Care
Medication Administration Pass
Safety-Incident Report
Head Injury Routine
Falls Prevention and Management
Documentation
Sanitization/Risk Management Personal Care Ware
Personal Expression Program using the Layered Natured Framework and the P.I.E.C.E.S Approach.

Grounds / Motifs :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

A clinical record review, staff and resident interviews revealed that the staff did not comply with the home's own policies, procedures and process, specifically related to below policies:

Mechanical lifts: mechanical lift was not used when a resident was found on the floor.
Nutrition and Hydration: plan for a previous order was not completed specifically for providing education for all staff providing direct care.
Infection Prevention and Control: no list kept of residents who have certain communicable diseases, signage was not posted, no notes in care plans.
Skin and Wound Care: skin assessment not completed post hospitalization and when new skin breakdown occurred and skin assessment concern forms not completed.
Medication Administration Pass: staff not remaining with residents when administering medications.
Safety-Incident Report: incident report forms were not fully completed.
Head Injury Routine: head injury routine assessment was not initiated.
Falls Prevention and Management: post fall assessment not completed.
Documentation: treatment records not fully completed.
Sanitization/Risk Management Personal Care: personal care items unlabelled.
Personal Expression Program: DOS charting not completed per policy.

This non-compliance was previously issued as Written Notification and a Compliance Order under r. 8 (1) (b) on September 9, 2015, Inspection #2015_217137_0040 and a compliance date of November 27, 2015.

This non-compliance was previously issued as a Written Notification and a Voluntary Plan of Correction on October 6, 2015.

This non-compliance was previously issued as Written Notification and a Compliance Order under r. 8 (1) (b) on December 18, 2015, Inspection #2015_183128_0023 and a compliance date of February 15, 2016.

During this inspection the licensee was found to have not met compliance with the above compliance order. (630)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 007

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall ensure that all doors leading to non-residential areas are kept locked when they are not being supervised by staff.

The licensee shall ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, and shall educate all staff on this policy.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept locked when they are not being supervised by staff.

A clinical record review and staff interviews revealed that a door leading to a non-residential area was left unsupervised while it was open. A resident was found in this non-residential area where resident had fallen and sustained an injury.

DON #102 confirmed that the home had failed to keep all doors locked when not supervised by staff. [s. 9. (1) 2.]

During this inspection this non-compliance was found to have a severity level of an actual harm/risk to a resident, this non-compliance was found to be an isolated incident with a previous unrelated history. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 008

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee shall ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

Grounds / Motifs :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

Observations during the Resident Quality Inspection revealed that some windows in the home had the tilt function that when activated opened the windows more than 15 centimetres.

The General Manager #101 and Director of Nursing #102 confirmed that the home's expectation was that every window in the home that opens to the outdoors and was accessible to residents could not be opened more than 15 centimetres. [s. 16.]

During this inspection this non-compliance was found to have a severity level of minimal harm/risk or potential for actual harm/risk to residents, this non-compliance was found to be widespread in the home and had an unrelated history. (523)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 31, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 009

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_183128_0023, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
The licensee shall ensure that the action plan submitted by the home in response to compliance order issued on December 18, 2015, under log # 031635-15 and inspection # 2015_183128_0023 with a compliance order date of December 30, 2015, is fully implemented, specifically but not limited to the following:
Team huddle when resident declines a bath.
Documentation of approach, declining and re-approach.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Clinical record review and staff interviews revealed that the home did not fully implement with the plan for a previous compliance order that was issued to ensure that a resident was offered a bath at a minimum twice a week, resident refusal and re-approach will be documented.

DON #102 confirmed that the home had not complied with the order. [s. 33. (1)]

This non-compliance was previously issued as a Written Notification and a Voluntary Plan of Correction on May 27, 2015.

This non-compliance was previously issued as Written Notification and a Compliance Order on December 18, 2015, Inspection #2015_183128_0023 and a compliance date of December 30, 2015.

During this inspection the licensee was found to have not met compliance with the above compliance order. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2016

Order # / Ordre no : 010

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall ensure that when responsive behaviors are exhibited by a resident, that this resident is assessed by members of the BSO team as required, and based on an interdisciplinary assessment will identify factors that could potentially trigger such altercation.
Interventions will be identified, documented in the resident's care plan and implemented to minimize the risk of altercations and potentially harmful interactions between residents.
Interventions will be evaluated for effectiveness and will be revised accordingly.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and (b) identifying and implementing interventions.

Clinical record reviews, staff interviews and review of Internal Incident Reports revealed that staff had identified responsive behaviours and altercations between different residents on several occasions.

DON #102 and Neighbourhood Coordinator #186 confirmed in an interview that there was a delay in identifying physical aggression and altercation between residents and a delay between the first incident of altercation between residents and the time the behaviour was assessed and interventions and strategies were developed and implemented.

DON #102 confirmed the home had failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents. [s. 54.]

During this inspection this non-compliance was found to have a severity level of an actual harm/risk to residents, this non-compliance was found to be widespread in the home with an unrelated history. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 011

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Order / Ordre :

The licensee shall ensure that a documented record was kept in the home for any complaint that includes the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, every date on which any response is provided to the complainant and a description of the response and any response made in turn by the complainant.

Grounds / Motifs :

1. The licensee has failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Clinical record reviews, staff, residents and family member's interviews revealed that the home did not keep a documented record of specified complaints raised by residents and/or family members.

Documentations regarding the actions and responses and final resolutions to the concerns were not completed. [s. 101. (2)]

This non-compliance was previously issued as a Written Notification on September 9, 2015.

This non-compliance was previously issued as a Written Notification and a Voluntary Plan of Correction on November 24, 2015.

During this inspection this non-compliance was found to have a severity level of minimal harm/risk or potential for an actual harm/risk to residents, this non-compliance was found to be a pattern and was an ongoing non-compliance in the home. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 012

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_183128_0023, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee shall ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Clinical record review and staff interviews revealed that a resident had received a medication that required an evaluation of the effectiveness of that medication. Further review revealed that there was no documentation of the resident's response to the medication and the effectiveness of that medication. [s. 134. (a)]

This non-compliance was previously issued as Written Notification and a Compliance Order on December 18, 2015, Inspection #2015_183128_0023 and a compliance date of January 15, 2016.

During this inspection the licensee was found to have not met compliance with the above compliance order. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 013

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Order / Ordre :

The licensee shall ensure that there was an interdisciplinary team approach in the co-ordination and implementation of the Infection Prevention and Control program; that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; that the local medical officer of health is invited to the meetings; that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and that a written record is kept relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes are implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an interdisciplinary team approach in the co-ordination and implementation of the program; that the interdisciplinary team that co-ordinates and implements the program met at least quarterly; that the local medical officer of health was invited to the meetings; that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and that a written record was kept relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Record review and staff interviews revealed that the home does not have an interdisciplinary Infection Prevention and Control program (IPAC), the IPAC did not meet quarterly, and there was no documentation of a full IPAC program evaluation including an evaluation of the program goals and strategies or any hand hygiene audits completed. [s. 229. (2)]

During this inspection this non-compliance was found to have a severity level of minimal harm/risk or potential for an actual harm/risk to residents, this non-compliance was found to be a pattern and was previously issued in a similar area. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 014

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that resident #003 receives encouragement and assistance during meal time, staff will document their approach and re-approach if needed and resident's refusal and behaviors exhibited, and staff will ensure that the resident is covered and kept warm while providing care as per the plan of care.

Grounds / Motifs :

1. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Clinical record and evidence review revealed that the care set out in the plan of care for resident #003 was not provided as specified in the plan.

The licensee failed to ensure that resident #003 received the care specified in the plan of care.[s. 6. (7)]

This non-compliance was previously issued as a Written Notification and a Voluntary Plan of Correction on May 25, 2015.

This non-compliance was previously issued as Written Notification and a Compliance Order under r. 8 (1) (b) on December 18, 2015, Inspection #2015_183128_0023 and compliance date of January 15, 2016, and was complied with on February 11, 2016.

During this inspection this non-compliance was found to have a severity level of minimal harm/risk or potential for an actual harm/risk to residents, this non-compliance was found to be an isolated incident but this was an ongoing non-compliance with the home. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 015

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program specifically but not limited to: Ensure medication is protected from contamination before providing to residents.

Develop and implement a plan to ensure that tables are set ensuring the prevention of contamination before the meal service begins.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A) During the RQI RN #150 was observed dropping two pills on the floor, pick them up off the floor and then gave them to the resident. Interview with RN #150 confirmed that she had dropped the pills on the floor and then picked them up off the floor and gave them to resident #044 to swallow.

Interview with General Manager #101 and Director of Nursing #102 that it was the expectation of the home that all staff would participate in the implementation of the infection prevention control including not giving residents medications that touch the floor.

B) Observations during the RQI revealed that the dining room tables on a specified neighbourhood set with cutlery and mugs and these were uncovered. Residents with cognitive impairment were observed wandering in the dining room at the time and touching multiple surfaces. The dining room did not have doors or gates to keep residents from entering the room.
Interview with Director of Food Services #147 identified that the process in the home was that tables were set mid-morning for the lunch, around 1600 for supper and then in the evening for the next day breakfast. She confirmed the practice in the home was to not cover the utensils or the cups and that some neighbourhood dining room do not have doors and residents wander.

She confirmed this was an infection prevention and control issue and that it was the expectation in the home that tables would be set in a manner to minimize risk of transmission of infections. [s. 229. (4)]

This non-compliance was previously issued as a Written Notification and a Voluntary Plan of Correction on November 24, 2014.

During this inspection this non-compliance was found to have a severity level of minimal harm/risk or potential for an actual harm/risk to residents, this non-compliance was found to be a pattern and was previously issued in a similar area. (630)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 016

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

O. Reg. 79/10, s. 229 (10).

Order / Ordre :

The licensee will ensure the following immunization and screening measures are in place:
1. All residents who have already been admitted to the home and have not been screened for tuberculosis are screened immediately.
2. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
3. Residents must be offered immunization against influenza at the appropriate time each year.
4. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Grounds / Motifs :

1. The licensee has failed to ensure that the following immunization and screening measures are in place:

Record review and interview with the Assistant Director of Nursing Care #117 confirmed that the home has not been compliant in monitoring the need for or providing immunizations for residents when required for pneumococcus, tetanus/diphtheria, influenza or in tuberculosis screening. [s. 229. (10)]

During this inspection this non-compliance was found to have a severity level of minimal harm/risk or potential for an actual harm/risk to residents, this non-compliance was found to be a pattern and was previously issued in a similar area. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 12th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ali Nasser

Service Area Office /
Bureau régional de services : London Service Area Office