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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 12, 2017	2017_607523_0007	007589-17	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), DONNA TIERNEY (569), INA REYNOLDS (524), MARIAN MACDONALD (137), TRACY RICHARDSON (680)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 18, 19, 20, 21, 24, 25, 26, 27 and 28, 2017.

The following inspections were completed concurrently during the RQI:

Follow Up Log # 023848-16 to compliance orders from inspection #2016_457630_0029 related to bed system assessments, immunization screening measures and locked doors policy.

Critical Incident Log # 015378-16 related to resident's fall.
Critical Incident Log # 030724-16 related to resident's fall.
Critical Incident Log # 002196-16 related to alleged resident to resident physical abuse.
Critical Incident Log # 030211-16 related to resident's fall.
Critical Incident Log # 009915-16 related to resident's fall
Critical Incident Log # 005255-17 related to resident's fall.
Critical Incident Log # 008556-17 related to resident's fall.
Critical Incident Log # 008560-17 related to resident's fall.

This inspection contains non compliance under r. 50. (2) (b) (iv) that was supporting evidence for compliance order # 001, inspection # 2017_538144_0009 and log # 002195-17 and 002373-17, issued on May 5, 2017, with compliance date of June 19, 2017.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Vice President of Operations, two Nurse Consultants, Acting Director of Nursing (ADON), Director of Environmental Services (DES), Food Services Manager, Physician, Administrative Coordinator, Kinesiologist, Director of Recreation, previous Acting General Manager, two Neighbourhood Coordinators, Personal Expression Response Team- Personal Support Worker, Dietary Aide, maintenance worker, two Physiotherapy Assisstants, four Resident Assessment Instrument (RAI) coordinators, 23 Personal Support Workers, four Registered Nurses, 15 Registered Practical Nurses, Family Council chairperson, three family members and forty 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:

Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **15 WN(s)**
- **8 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 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 protected from neglect by the licensee or staff in the home.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment care, services or assistance required for health, safety or well-being, and includes inaction or pattern of inaction that jeopardizes the health, safety or well-bring of one or more residents.

A Critical Incident System (CIS) report showed that a resident had a fall on a certain date that resulted in an injury and change in condition.

A review of the home's internal investigation records and staff interviews showed that the resident was not checked as frequently as was specified in the plan of care.

In an Interview, the GM acknowledged that the staff did not conduct the checks on the resident as expected.

During this inspection, this non-compliance was found to have a severity level of actual harm/risk, the scope was isolated and there was a previous non-compliance issued in this area as follows:
This was previously issued on October 19, 2015, as a Written Notification and Voluntary Plan of Correction under complaint log #027142-15 and inspection #2015_262523_0026.
This was previously issued on May 12, 2016, as a Written Notification and Compliance Order under Resident Quality Inspection Log # 007195-16 and inspection # 2016_262523_0016 with a compliance date of May 31, 2016.
This was previously issued on July 27, 2016, as a Written Notification and Compliance Order under Follow up inspection log #017014-16 and inspection #2016_262523_0026 with a compliance date of August 31, 2016. [s. 19. (1)]

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

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).

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

Findings/Faits saillants :

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

Observations on multiple occasions during the RQI showed unlabeled personal care items in the tub and shower rooms.

Review of Policy Personal Care Ware, not dated, stated to "ensure all personal ware were labelled with resident name and/or room number, including but not limited to, basin, cup, denture cup, personal care products".

In interviews, staff said that the unlabelled items in the tub room should not be in the tub room and should have been labelled. Staff did not know who some of those items belonged to.

The Acting Director of Nursing stated that all personal items should be labelled and if found unlabelled they would be thrown in the garbage.
The Acting Assistant Director of Nursing stated that it was an expectation that every resident have their own personal care items.

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program, personal care items were found on three different occasions unlabelled and had been noted to be used. [s. 229. (4)]

2. The licensee has failed to ensure that on every shift the symptoms of infection in residents were recorded and immediate action was taken as required.

A) Progress notes review for a resident showed that on a certain date they expressed symptoms of infection that required interventions.

Staff interview showed that the expectation would be to monitor vital signs (V/S), infection status and symptoms every shift and document this information in the progress notes.
Clinical record review with staff showed no documentation on V/S or resident's symptoms of infection.

A RPN said that the expectation was to have a progress note on every shift that would reflect the assessment of the resident, V/S and symptoms of infection and any action that was taken.

Acting DON said that the home's expectation and best practice was to assess the resident on every shift after the first symptom of infection was identified, V/S will be part of the assessment.
The ADON reviewed the clinical record and acknowledged that the resident had an infection identified and that there was no progress note following the onset of the infection on every shift to assess signs of infections.
The ADON said that this did not meet the home's expectations, monitoring should be completed on every shift and documented as well. [(523)]

B) Clinical record review showed that a resident expressed symptoms of infection.

Clinical record review and staff interviews showed that there was no recorded assessments or daily monitoring completed for the resident.

The Acting Director of Nursing stated in an interview that the expectation was for the resident to be monitored daily, assessed as needed and the daily monitoring record would be completed every shift.

The licensee has failed to ensure that on every shift, the symptoms of infection in identified residents were recorded and immediate action was taken as required. [s. 229. (5) (b)]

3. The licensee has failed to ensure the following immunization and screening measures were in place: 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. Staff were screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

This was a follow up to an order that was previously issued on August 5, 2016, under log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016.
The order included that: 'the licensee will ensure the following immunization and screening measures are implemented and documented:
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.
The licensee shall develop and implement an audit to ensure the TB screening measures are completed as required by the legislation. The licensee shall appoint a management or supervisory staff person to complete the audits. This audit will be documented and reviewed on a monthly basis with the GM'.

A clinical record review with a RPN showed that some TB screenings for specific residents were not done at all or were not done within 14 days of admission.

The Nurse Consultant said in an interview that they were not able to find any documented audits for the TB screening that were to be completed monthly and

reviewed by the GM on a monthly basis.

The GM said in an interview that there was no formal audit that was completed, documented and reviewed by them at the end of every month.

The Nurse Consultant and the GM acknowledged that specific residents did not receive TB screenings within 14 days of admission, and that the home had not complied with the compliance order.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be a pattern. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order.
This was previously issued on May 12, 2016, as a Written Notification and a Compliance Order under Resident Quality Inspection log #007195-16 and inspection # 2016_262523_0016 with a compliance order dated of June 30, 2016.
This was previously issued on August 5, 2016, as a Written Notification and Compliance Order under Follow Up log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016. [s. 229. (10) 1.]

4. The licensee has failed to ensure the following immunization and screening measures were in place: staff were screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there were none, in accordance with prevailing practice.

Information provided showed that specific staff members did not have their TB screen done or on file at the home.

Review of the policy, not dated, titled Tuberculosis Prevention Program showed that: “All team members will have a two-step TB skin test started with 14 days of employment unless they are known to be positive, or can provide proof of testing within the last year. If a team member has two or more documented negative tuberculin skin tests (TST's) at any time, but the most recent was over 12 months ago, a single-step test may be given."

The Administrative Coordinator stated that it was an expectation that 100% of staff have their TB testing done within 14 days of hire. The staff who did not provide this were to be removed from the schedule. The Administrative Coordinator stated that the staff who had

not had their TB test on file within the last year had not been removed from the schedule and have continued to work without the testing being completed. Administrative coordinator stated that 89% of active staff had their testing completed.

The licensee has failed to ensure that staff were screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there were none, in accordance with prevailing practice, 100% of staff were not tested for Tb and are continuing to work within the facility.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be a pattern. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order.
This was previously issued on May 12, 2016, as a Written Notification and a Compliance Order under Resident Quality Inspection log #007195-16 and inspection # 2016_262523_0016 with a compliance order dated of June 30, 2016.
This was previously issued on August 5, 2016, as a Written Notification and Compliance Order under Follow Up log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016. [s. 229. (10) 4.]

Additional Required Actions:

CO # - 002 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 on every shift the symptoms of infection in residents were recorded and immediate action was taken as required, and to ensure that personal items for residents were labelled, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure 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. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that dealt with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

This was a follow up to an order that was previously issued on August 5, 2016, under log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016.

The order included that 'The licensee shall ensure that there was a written policy that dealt 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'.

In an interview, the GM reviewed the compliance order and provided inspector with the required policy and the attendance record for staff education.
A review with the GM showed that the Building Safety and Security Policy tab 01-05 did not have a revision date. The GM said that the policy was updated on May 4, 2016.
A review of the policy showed that the policy did not deal with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.
The GM acknowledged that this was the same policy used at the time of the previous inspection when the compliance order was issued. The education attendance record for the staff showed that some education sessions were provided using this policy before the home received the inspection report and compliance order.

The GM acknowledged that the policy did not include direction to staff as to when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents and said that the order was not complied with.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be a pattern. The home had ongoing non-compliance with this section of the legislation including previous issuance of an order.
This was previously issued as a Compliance Order on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with a compliance order date of June 30, 2016.
This was previously issued as a Compliance Order on August 5, 2016, under log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016. [s. 9. (2)]

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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

This was a follow up to an order that was previously issued on August 5, 2016, under log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016.

The order included that the licensee shall ensure identified residents were reassessed in their bed system.
The licensee shall ensure the bed entrapment failed zones in identified rooms were fixed and a bed entrapment reassessment completed.
The licensee shall ensure residents were reassessed in their bed systems after a change in the system such as new mattress.
The licensee shall develop and implement an audit to ensure all residents using bed rails were assessed in their bed systems and that all bed systems were assessed in accordance with the legislation.
The licensee shall appoint a management or supervisory staff person to complete the audits. This audit will be documented and reviewed with the GM by the compliance date and ongoing on a monthly basis.

The compliance date for the order was September 30, 2016.

A review of the clinical record showed that specific residents had no assessments completed prior to the compliance date.

A review of the entrapment audit report showed some residents had bed entrapment assessment completed two months or more after new beds were provided to the residents.

Inspector asked if an audit was developed and implemented to ensure all residents using bed rails were assessed in their bed systems and that all bed systems were assessed in accordance with the legislation, and if the appointed management or supervisory staff person completed, documented and reviewed the audits with the GM by the compliance date and ongoing on a monthly basis.

The GM and the DES were not able to present a documented audit for the bed assessments that were completed and then reviewed by the GM on a monthly basis. DES and GM acknowledged that the audits were not developed, documented and reviewed by the GM on a monthly basis and that the Compliance Order was not fully complied with.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be a pattern. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order.

This was previously issued on May 16, 2016, as a Written Notification and Compliance Order under Complaint log # 008735-16 and inspection #2016_262523_0019 with a compliance order date of May 31, 2016.
This was previously issued on August 5, 2016, as a Written Notification and Compliance Order under Follow Up log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016. [s. 15. (1) (a)]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care had set out clear directions to staff and others who provided direct care to the resident.

A) A clinical record review for a resident showed that the resident had a certain number of falls in a specific month, one of which resulted in an injury. The next month the

resident had falls including multiple falls a day on consecutive days that resulted in severe injuries and change in condition.
A clinical record review showed that the plan of care identified the resident as a low risk for falls, in the same care plan the resident was identified as a medium to high risk for falls.

The Kinesiologist and The RAI-RPN reviewed and acknowledged that the plan of care showed the resident to be low risk for falls, at the same time the resident was on the Falling Leaf Program indicating moderate to high risk for falls. They said that the plan of care should be reflective of the resident's current state and should set out clear direction to staff and others who provided direct care to the resident.

The Kinesiologist and The RAI-RPN acknowledged that the plan of care did not set out clear direction to staff. [(523)]

B) Huddle notes for a certain date stated that a resident was "making inappropriate comments to staff and residents". In the plan of care it was noted that the resident had inappropriate sexual behaviours and the only intervention listed was to bring the resident to their room. No other responsive behaviour interventions were in the plan of care regarding inappropriate comments.

Review of the policy, not dated, Tab 04-84 titled Personal Expression Program Using the Layered Natured Framework and the P.I.E.C.E.S. approach, stated that once an understanding of the resident's personal expression had been identified and understood that they would update the resident's plan of care. The responsive behaviour charting on February 5, 2017, for the resident talked about the resident's inappropriate comment during bathing.

In interviews, staff stated that the resident had made sexually inappropriate comments to staff and that the resident was resistive to care.
A RPN said that they were unaware of the sexual inappropriateness expressed by the resident and it was the expectation that staff communicate those changes. The RPN stated that staff could change the plan of care as alterations were required and that the RPN would quarterly update this plan of care electronically.

The Acting Director of Nursing (ADON) stated the expectation was that new behaviours would have Dementia Observation System (DOS) charting to show trends, that a referral to Personal Expressions Resource Team (PERT) would be done, and that the care plan

would be specific with interventions that should be utilized. The ADON acknowledged that there was not a clear direction to staff regarding resident's behaviours.

The licensee has failed to ensure that the plan of care had set out clear directions to staff and others who provided direct care to the resident. The plan of care for the resident did not include interventions for all of the resident's responsive behaviours.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This area of non-compliance was previously issued as a:
Written Notification and a Compliance Order on December 18, 2015, under Complaint Log # 031635-15 and inspection # 2015_183128_0023. Compliance Order was complied with on February 11, 2016.
Written Notification and Voluntary Plan of Correction on October 19, 2015, under Resident Quality Inspection Log # 024284-15 and Inspection # 2015_217137_0040 [s. 6. (1) (c)]

2. The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed related to responsive behaviours.

A Critical Incident System (CIS) report submitted on a certain date, related to an altercation between residents whereby one of the residents sustained possible injury.

A review of the Minimum Data Set (MDS) assessment showed a change in the resident's responsive behaviours.

A clinical record review and interview with the Personal Expression Response Team (PERT) Personal Support Worker (PSW) showed the resident had an increase in behaviours, and the plan of care had not been reviewed and revised when the resident's care needs changed, related to responsive behaviours.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This area of non-compliance was previously issued as a:
A Written Notification and Voluntary Plan of Correction on August 26, 2016, under Resident Quality Inspection Log # 007195-16 and Inspection # 2016_262523_0016. [s. 6. (10) (b)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change.

Progress note review showed that on a certain date a specific resident had a fall and sustained an injury, transferred to hospital and a change of condition was discovered.

After return to the home there was no update to the plan of care related to the change in condition.

The ADON acknowledged in an interview that the plan of care was not updated to reflect the change in the resident's status, and said that it was the expectation that staff would update the plan of care when there was a change in the resident status and their care needs have changed.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This area of non-compliance was previously issued as a: A Written Notification and Voluntary Plan of Correction on August 26, 2016, under Resident Quality Inspection Log # 007195-16 and Inspection # 2016_262523_0016. [s. 6. (10) (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 plan of care had set out clear directions to staff and others who provided direct care to the resident, and to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's vision.

Record review of a certain assessment and staff interviews showed that the resident had a specific level of impairment.

Record review of the plan of care showed no focus statement, goals or interventions with respect to the specific impairment based on the assessment.

The RPN-Resident Assessment Instrument (RAI) Coordinator acknowledged the absence of goals and interventions related to the specific impairment in the plan of care and that it was the expectation that there should have been.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This area of non compliance was not previously issued. [s. 26. (3) 4.]

2. The licensee has failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's skin condition, including altered skin integrity.

Record review for a certain resident and staff interviews showed that the resident had an altered skin integrity.

Record review of the plan of care showed no focus statement, goals or interventions with respect to the resident's altered skin integrity.

The home's policy titled "Skin and Wound Care Program" tab 04-78 not dated, stated that the registered team member would ”develop interventions that address risk items identified and implement inter-professional plan of care to prevent skin breakdown”.

A RN acknowledged the absence of strategies and interventions related to the resident's altered skin integrity. RPN Skin and Wound Lead agreed that strategies related to the resident's altered skin integrity should have been in the plan of care and it was not.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This area of non compliance was not previously issued. [s. 26. (3) 15.]

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 a plan of care was based on, at a minimum: An interdisciplinary assessment of the resident's vision, and skin condition, including altered skin integrity, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide in the home, followed by the report required under subsection (4).

Review of a resident's progress notes showed that on a certain date they had a fall that resulted in an injury and change in condition. The resident passed away later on that date.
A review of Critical Incident System (CIS) showed the CIS report was completed two days after the fall and the death had occurred.

The ADON said that the resident had a fall that resulted in a head injury, change in

condition and death, and that reporting to the Director was not completed within one business day.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This area of non compliance was not issued previously. [s. 107. (1) 2.]

2. The licensee has failed to ensure that the Director was informed of the incidents, which resulted in injury of which a person was taken to hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4)

Review of a resident's progress notes showed that on a certain date the resident had a fall that resulted in an injury and change in condition that required transfer to hospital to receive treatment.

A review of Critical Incident System (CIS) showed the CIS report was completed three days after the fall had occurred.

The ADON said that the resident was transferred to hospital post fall and that there was a change in their condition, and that reporting to the Director was not completed within one business day.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This area of non compliance was not issued previously. [s. 107. (3) 4.]

3. The licensee has failed to make in writing a report to the Director setting out the following with respect to the incident:
The long-term actions planned to correct the situation and prevent recurrence.

The ADON said that the CIS was not amended to include the required information. They said the expectation would be to complete the CIS with the required information and to amend with requested information once available.

During the inspection this non-compliance was found to have the severity level of

minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This area of non compliance was not issued previously. [s. 107. (4) 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 Director is immediately informed, in as much detail as was possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide in the home, followed by the report required under subsection (4),to ensure that the Director was informed of the incidents, which resulted in injury of which a person was taken to hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4), and to make in writing a report to the Director setting out the following with respect to the incident: the long-term actions planned to correct the situation and prevent recurrence, to be implemented voluntarily.

WN #8: 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 were stored in an area or a medication cart that was secure and locked and 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.

Observation on a certain date during the inspection showed maintenance staff working on the medication cart inside the medication room. The medication cart was unlocked, the narcotic box inside the medication cart was unlocked and open.

The RPN said that they were in the medication room with the maintenance staff but left to administer medications. RPN acknowledged that they should have not left non nursing staff in the medication room with access to narcotics and other medications.

The Nurse Consultant said that the expectation was to have a nurse in attendance when the maintenance staff were in the med room and working on the med cart to ensure safe storage of drugs.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated and this area of non compliance was previously issued as a:
Written Notification and Voluntary Plan of Correction on August 5, 2016, under Follow UP Log # 017016-16, 014960-16 and Inspection # 2016_457630_0029
Written Notification and a Compliance Order on May 12, 2016, under Resident Quality Inspection Log # 007195-16 and Inspection #2016_262523_0016. Compliance Order was complied with on July 5, 2016.
Written Notification and a Compliance Order on October 19, 2015, under Resident Quality Inspection Log # 024284-15 and Inspection # 2015_217137_0040. Compliance Order was closed with a link. [s. 129. (1)]

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 were stored in an area or a medication cart that was secure and locked and 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, to be implemented voluntarily.

WN #9: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Clinical Record review for a resident and staff interviews showed that the resident was administered a certain drug and that there was no doctor's orders or medical directives for this drug to be given to the resident.

The Acting Director of Nursing (ADON) stated that there was no documented order for the drug that was administered to the resident.

The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This area of non compliance was not previously issued. [s. 131. (1)]

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).
(2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed;
(b) corrective action was taken as necessary; and
(c) a written record was kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).
(3) Every licensee shall ensure that,
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review were implemented; and
(c) a written record was kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

A review of the Medication Incidents Binder, showed a specific number of incidents that had no documented evidence that immediate actions were taken to assess and maintain the residents' health, not reported to resident, substitute decision maker (SDM), Director of Care, attending physician, Medical Director or pharmacy provider, were not reviewed and not analyzed.

As per the home's policy, Medication Incidents #4.15, revised March 1, 2016, "The Director of Care or Pharmacy Manager, as appropriate, investigates the medication incident, identifying factors contributing to the incident and documents findings on the Medication Incident/Near Miss form".

As per the same policy, "All medication incidents are reviewed and analyzed quarterly by the Professional Advisory Committee (PAC) and recommendations for system improvements developed.

During an interview, the Acting Director of Nursing said that the General Manager (GM) was not able to locate any PAC meeting minutes. The Acting DON said there was no evidence that a quarterly review was completed..

During the inspection this non-compliance was found to have the severity level of

minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated and there was no previous non compliance in this area. [s. 135.]

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 medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health and reported to the resident, the resident's substitute decision-maker, the Director of Care, the attending physician, Medical Director and the pharmacy service provider,
• That all medication incidents and adverse drug reactions were documented, reviewed and analyzed, that corrective action was taken as necessary and a written record was kept of everything required,
• That a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, and changes and improvements identified were implemented and a written record was kept of everything provided for, to be implemented voluntarily.

WN #11: 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) A review of the Medication Administration Records (MARs) for a resident, a certain task was to be checked twice a day.
A review of the MARs showed the task was not completed as ordered on many occasions and on several occasions there was no initials and no reason why it was not completed.

The RAI-RPN acknowledged that the tasks were not signed off. They said that the expectation was to sign off on treatment and medications as they were completed. They acknowledged that the documentation for completing treatments and checks was not completed accordingly and that the resident's record was not kept up to date.

B) A review of a resident's care plan showed hand written notes added to the care plan that included two interventions for falls prevention. Both interventions were not signed or initialed, one intervention did not have a documented date.
The RAI-RPN and the Kinesiologist reviewed the plan of care and acknowledged that the plan of care was updated and no signature and proper dating for the intervention was included, and said that any updated information added to the resident record would have a date and signature.
They said that the documentation for updating resident's record was not completed accordingly and that the resident's record was not kept up to date.

C) A review of Head Injury Routine (HIR) progress notes showed documentation that a resident refused HIR. In the same assessment the vital signs (V/S) showed as taken with various different previous dates.
The ADON and the RAI-RPN reviewed the HIR and said that when the V/S information section was not completed during the assessment, the information would be pulled from previous dates.
The ADON and the RAI-RPN acknowledged that this would reflect inaccurate information and that the resident's record was not kept up to date.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated and this area of non compliance was previously issued as a: Written Notification and a Voluntary Plan of Correction on May 12, 2016, under Resident Quality Inspection Log # 007195-16 and Inspection #2016_262523_0016. [s. 231.]

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 of a long-term care home shall ensure that the resident's written record was kept up to date at all times, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy Tab 04-52 titled The Restraint and PASD Procedures in LTC was complied with.

On a certain date during the inspection, a resident was observed over a period of three hours, the resident did not have their restraint released during the time of the observation.
Clinical record review showed no documentation that the restraint was released every 2 hours.
Personal Support Workers (PSW) stated in interviews that they did not reposition the resident during that time.

Review of the policy Restraint and PASD Procedures in LTC, tab 04-52 not dated, stated that Personal Care Assistants (PCA) will perform restraint monitoring using the restraint monitoring chart and will initial the form at the end of each shift.
The following will be completed and documented on the form:
-the resident will be monitored when the restraint is in place at least every hour by a PCA or designate to ensure that they restraint is intact and the resident is comfortable (safety check)
-the resident will be released from the restraint at least once every two hours or more frequently as required.

The Nurse Consultant reviewed the clinical record and said that the documentation indicated that on several occasions the resident was not repositioned every two hours, and stated that it was the expectation that the restraint would be released every two hours and the resident repositioned.

The licensee has failed to ensure that the policy Restraint and PASD Procedures in LTC was complied with and that the restraint was released every two hours and the resident repositioned.

During the inspection this non-compliance was found to have the severity level of minimal risk to the resident. The scope of the non-compliance was isolated. This are of non compliance was not previously issued. [s. 29. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's desired bedtime and rest routine was supported and individualized to promote comfort, rest and sleep.

In an interview, a resident said that they told staff that they liked to wake up at a certain time, but staff don't do wake them up at that time. The resident said "the time they wake me up was based on who was working and how busy they were. They did not honor what I liked".

On a later date the resident informed the inspector that today they woke them up at an earlier time.

In interviews, PSWs reviewed the clinical record with the inspector and said that today they woke the resident up earlier than that time specified in the plan of care. Staff said that the resident was being awaken up at a time not of their choice.

In an interview, the Neighbourhood Coordinator (NC) said that it was the resident's right to choose when to wake up in the morning, the team would discuss this with the resident/family and this would be documented in the plan of care.
A review of the plan of care showed the resident's preferred time to wake up. The NC said that this would mean that staff would go in the resident room at that time to wake them up.

NC acknowledged that the plan of care was not complied with for the resident's wake up time and said the expectation was to wake resident's up at their preferred time.

During the inspection this non-compliance was found to have the severity level of minimal risk to residents. The scope of the non-compliance was isolated and this area of non compliance was not issued previously. [s. 41.]

WN #14: 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 breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The following is an additional evidence to support Compliance Order #001 identified in inspection #2017_538144_0009 issued on May 5, 2017, with a compliance date of June 19, 2017.

Review of the clinical records for an identified resident showed that the resident had received treatment for an altered skin integrity. Continued review of the resident's clinical record showed that the resident's altered skin integrity was not reassessed by a member of the registered staff on multiple occasions.

A Registered Nurse acknowledged that there was no documentation found with respect to weekly skin assessments related to the altered skin integrity for the identified dates.

The home's policy titled "Skin and Wound Care Program" tab 04-78 not dated, stated that the registered team member would complete assessments of the areas of altered skin integrity and weekly thereafter.

During an interview, the Skin and Wound Lead said that it was the home's expectation that skin assessments were completed at least weekly for altered skin integrity concerns and they were not.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This area of non-compliance was previously issued as a: Written Notification and a Voluntary Plan of Correction on May 12, 2016, under Resident Quality Inspection Log # 007195-16 and Inspection #2016_262523_0016. [s. 50. (2) (b) (iv)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Findings/Faits saillants :

1. The licensee failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

During the inspection it was noted that the required legislated information related to the home's policy to promote zero tolerance of abuse and neglect of residents, notification of the home's policy to minimize the restraining of residents and how a copy of the policy can be obtained, and an explanation of whistle-blowing protection were not posted in a conspicuous easily accessible location in the home.

In an Interview, the General Manager (GM) said that those policies were outlined in the home's resident handbook that was provided to residents and families on admission, during tours or upon request.

The inspector and GM together toured specific areas of the home, the name and telephone number of the licensee and an explanation of the home's evacuation procedures were not observed to be posted in any of the toured areas. The Environmental Services Manager said that the evacuation procedures were not posted in the home.

The General Manager agreed that the required information of the home's policies to promote zero tolerance of abuse and neglect, minimize the restraining of residents, and whistle-blowing protection were not posted in a conspicuous location, and the name and telephone number of the licensee, and the home's evacuation procedures were not posted in the home as required by legislation.

During the inspection this non-compliance was found to have the severity level of minimal risk to residents. The scope of the non-compliance was isolated. This area of non compliance was not issued previously. [s. 79.]

Issued on this 28th day of September, 2017

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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALI NASSER (523), DONNA TIERNEY (569), INA REYNOLDS (524), MARIAN MACDONALD (137), TRACY RICHARDSON (680)
Inspection No. / No de l'inspection :	2017_607523_0007
Log No. / No de registre :	007589-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 12, 2017
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 :	Laurie Schneider

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)

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 residents are not neglected by the licensee or staff including but not limited to:
Ensuring that if a resident requires a bed alarm, the bed alarm is functioning and applied correctly.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from neglect by the licensee or staff in the home.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment care, services or assistance required for health, safety or well-being, and includes inaction or pattern of inaction that jeopardizes the health, safety or well-bring of one or more residents.

A Critical Incident System (CIS) report showed that a resident had a fall on a certain date that resulted in an injury and change in condition.

A review of the home's internal investigation records and staff interviews showed that the resident was not checked as frequently as was specified in the plan of care.

In an Interview, the GM acknowledged that the staff did not conduct the checks on the resident as expected.

During this inspection, this non-compliance was found to have a severity level of actual harm/risk, the scope was isolated and there was a previous non-compliance issued in this area as follows:
This was previously issued on October 19, 2015, as a Written Notification and Voluntary Plan of Correction under complaint log #027142-15 and inspection #2015_262523_0026.
This was previously issued on May 12, 2016, as a Written Notification and Compliance Order under Resident Quality Inspection Log # 007195-16 and inspection # 2016_262523_0016 with a compliance date of May 31, 2016.
This was previously issued on July 27, 2016, as a Written Notification and Compliance Order under Follow up inspection log #017014-16 and inspection #2016_262523_0026 with a compliance date of August 31, 2016. [s. 19. (1)] (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_457630_0029, CO #004;

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 shall ensure the following immunization and screening measures are implemented and documented:
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.Each 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.
4.The licensee shall develop and implement an audit to ensure the TB screening measures are completed as required by the legislation.

Grounds / Motifs :

1. The licensee has failed to ensure the following immunization and screening measures were in place: 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. Staff were screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

This was a follow up to an order that was previously issued on August 5, 2016, under log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016.
The order included that: 'the licensee will ensure the following immunization and screening measures are implemented and documented:
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.
The licensee shall develop and implement an audit to ensure the TB screening measures are completed as required by the legislation. The licensee shall appoint a management or supervisory staff person to complete the audits. This audit will be documented and reviewed on a monthly basis with the GM'.

A clinical record review with a RPN showed that some TB screenings for specific residents were not done at all or were not done within 14 days of admission.

The Nurse Consultant said in an interview that they were not able to find any documented audits for the TB screening that were to be completed monthly and reviewed by the GM on a monthly basis.

The GM said in an interview that there was no formal audit that was completed, documented and reviewed by them at the end of every month.

The Nurse Consultant and the GM acknowledged that specific residents did not receive TB screenings within 14 days of admission, and that the home had not complied with the compliance order.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be a pattern. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order.
This was previously issued on May 12, 2016, as a Written Notification and a Compliance Order under Resident Quality Inspection log #007195-16 and inspection # 2016_262523_0016 with a compliance order dated of June 30, 2016.
This was previously issued on August 5, 2016, as a Written Notification and Compliance Order under Follow Up log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016. [s. 229. (10) 1.] (523)

2. The licensee has failed to ensure the following immunization and screening measures were in place: staff were screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there were none, in accordance with prevailing practice.

Information provided showed that specific staff members did not have their TB screen done or on file at the home.

Review of the policy, not dated, titled Tuberculosis Prevention Program showed

that: "All team members will have a two-step TB skin test started with 14 days of employment unless they are known to be positive, or can provide proof of testing within the last year. If a team member has two or more documented negative tuberculin skin tests (TST's) at any time, but the most recent was over 12 months ago, a single-step test may be given."

The Administrative Coordinator stated that it was an expectation that 100% of staff have their TB testing done within 14 days of hire. The staff who did not provide this were to be removed from the schedule. The Administrative Coordinator stated that the staff who had not had their TB test on file within the last year had not been removed from the schedule and have continued to work without the testing being completed. Administrative coordinator stated that 89% of active staff had their testing completed.

The licensee has failed to ensure that staff were screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there were none, in accordance with prevailing practice, 100% of staff were not tested for Tb and are continuing to work within the facility.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be a pattern. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order.
This was previously issued on May 12, 2016, as a Written Notification and a Compliance Order under Resident Quality Inspection log #007195-16 and inspection # 2016_262523_0016 with a compliance order dated of June 30, 2016.
This was previously issued on August 5, 2016, as a Written Notification and Compliance Order under Follow Up log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016. [s. 229. (10) 4.] (680)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2016_457630_0029, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (2) The licensee shall ensure 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. O. Reg. 363/11, s. 1 (3).

Order / Ordre :

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 there was a written policy that dealt with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

This was a follow up to an order that was previously issued on August 5, 2016, under log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016.

The order included that 'The licensee shall ensure that there was a written policy that dealt 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'.

In an interview, the GM reviewed the compliance order and provided inspector with the required policy and the attendance record for staff education.
A review with the GM showed that the Building Safety and Security Policy tab 01 -05 did not have a revision date. The GM said that the policy was updated on May 4, 2016.

A review of the policy showed that the policy did not deal with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.
The GM acknowledged that this was the same policy used at the time of the previous inspection when the compliance order was issued. The education attendance record for the staff showed that some education sessions were provided using this policy before the home received the inspection report and compliance order.

The GM acknowledged that the policy did not include direction to staff as to when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents and said that the order was not complied with.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be a pattern. The home had ongoing non-compliance with this section of the legislation including previous issuance of an order.
This was previously issued as a Compliance Order on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with a compliance order date of June 30, 2016.
This was previously issued as a Compliance Order on August 5, 2016, under log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016. [s. 9. (2)] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2016_457630_0029, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure that all residents are reassessed in their bed systems after a change in the system such as but not limited to a new mattress.

The licensee shall ensure all residents using bed rails are assessed in their bed systems and that all bed systems are assessed in accordance with the legislation.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

This was a follow up to an order that was previously issued on August 5, 2016, under log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016.
The order included that the licensee shall ensure identified residents were reassessed in their bed system.
The licensee shall ensure the bed entrapment failed zones in identified rooms

were fixed and a bed entrapment reassessment completed.
The licensee shall ensure residents were reassessed in their bed systems after a change in the system such as new mattress.

The licensee shall develop and implement an audit to ensure all residents using bed rails were assessed in their bed systems and that all bed systems were assessed in accordance with the legislation.
The licensee shall appoint a management or supervisory staff person to complete the audits. This audit will be documented and reviewed with the GM by the compliance date and ongoing on a monthly basis.

The compliance date for the order was September 30, 2016.

A review of the clinical record showed that specific residents had no assessments completed prior to the compliance date.

A review of the entrapment audit report showed some residents had bed entrapment assessment completed two months or more after new beds were provided to the residents.

Inspector asked if an audit was developed and implemented to ensure all residents using bed rails were assessed in their bed systems and that all bed systems were assessed in accordance with the legislation, and if the appointed management or supervisory staff person completed, documented and reviewed the audits with the GM by the compliance date and ongoing on a monthly basis.

The GM and the DES were not able to present a documented audit for the bed assessments that were completed and then reviewed by the GM on a monthly basis.
DES and GM acknowledged that the audits were not developed, documented and reviewed by the GM on a monthly basis and that the Compliance Order was not fully complied with.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be a pattern. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order.
This was previously issued on May 16, 2016, as a Written Notification and

Compliance Order under Complaint log # 008735-16 and inspection #2016_262523_0019 with a compliance order date of May 31, 2016.
This was previously issued on August 5, 2016, as a Written Notification and Compliance Order under Follow Up log #017016-16 & #014960-16 and inspection #2016_457630_0029 with a compliance order date of September 30, 2016. [s. 15. (1) (a)] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12th day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

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

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