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
Oct 22, 2018	2018_532590_0019	012928-18, 012932-18, 012935-18	Follow up

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 at St. Clair
1800 Talbot Road WINDSOR ON N9H 0E3

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

ALICIA MARLATT (590), CASSANDRA TAYLOR (725)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 1 - 5 and 9 - 12, 2018.

Follow-up to Order #001 related to prevention of abuse and neglect items were inspected and captured in another inspection that was completed concurrently with this inspection. Please refer to Complaint inspection #2018_747725_0017 with associated Log #015336-18, 024601-18, 024781-18 and 025106-18.

During the course of the inspection, the inspector(s) spoke with the Director of Care, an Assistant Director of Care, the Director of Environmental Services, a Neighbourhood Coordinator, a Housekeeper, two Registered Nurses, four Registered Practical Nurses and six Personal Support Workers.

During the course of the inspection, the inspector(s) observed infection prevention and control practices, dining services, recreational activities, resident home areas, and staff and resident interactions.

During the course of the inspection, the inspector(s) reviewed resident's clinical records, line listings and relevant policies and procedures related to infection prevention and control, and prevention of abuse and neglect.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_563670_0003	725
O.Reg 79/10 s. 50. (2)	CO #002	2018_563670_0003	725

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. This area of non-compliance was originally issued as a compliance order in a Resident

Quality Inspection #2018_563670_0003 on May 24, 2018, with a compliance date of July 23, 2018.

The licensee had failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Resident #008 was identified as having had an infection over an 19 day identified time period in 2018.

On the first day of illness, it was noted in a progress note that the resident was displaying specific infectious symptoms. The nurse practitioner assessed resident #008 the second day and no orders were received at that time.

Four days later, resident #008 had an increase in the display of their symptoms. The physician assessed resident #008 on the fourth day of illness, and orders were given for a 10 day cycle of antibiotics.

Review of the clinical record for resident #073 showed that the resident had not been monitored related to their infection for 18 percent of the time they were ill.

Review of the August 2018, unit surveillance document showed that resident #008 was added to the list on a specific day, though it was a onetime documentation of symptoms with no assessment or follow-up indication.

During an interview on October 11, 2018, Assistant Director of Care (ADOC) #101 stated it was the expectation that residents exhibiting signs and symptoms of infections would be assessed and documentation completed every shift. ADOC #101 indicated that documentation occurred on the surveillance sheet and in PCC. On review of the surveillance sheet ADOC #101 acknowledged that it did not meet the regulations regarding documentation for infection control and that staff had not documented the monitoring on every shift. [s. 229. (5) (a)]

2. Resident #009 was identified as having had an infection over an identified time period in 2018. On the first day it was noted in a progress note that symptoms were observed.

The home noted the illness on a specific day, and notified the physician of the illness. The physician assessed resident #009 on that day and ordered a 7 day cycle of

antibiotics.

Review of the clinical record for resident #009 showed that the resident had not been monitored related to their infection for 8 percent of the time they were ill.

Review of the surveillance document for the identified unit and time frame, showed that resident #009 was added to the list on the first day of illness, though it was a onetime documentation of symptoms with no assessment or follow-up indication.

During an interview on October 11, 2018, Assistant Director of Care (ADOC) #101 confirmed that no documentation was completed for resident #009 on the noted shifts and should have been. [s. 229. (5) (a)]

3. Resident #010 was identified as having symptoms of an infection over an identified time period in 2018.

The home noted the illness on the first day, and documented the resident's symptoms. The home notified the Nurse Practitioner (NP) the following day and received telephone orders for a 10 day antibiotic treatment. The following day, resident #010 was assessed by the Physician.

Review of the clinical record for resident #010 showed that the resident had not been monitored related to their infection for 17 percent of the time they were ill.

Review of the surveillance document for the identified unit and time frame showed that resident #010 was added to the list on a specific day, though it was a onetime documentation of symptoms with no assessment or follow-up indication.

During an interview on October 11, 2018, Assistant Director of Care (ADOC) #101 confirmed that no documentation was completed for resident #010 on the identified dates.

Review of the homes policy titled "Infection Control Surveillance "Tab 01-02 indicated that staff were to document on every shift.

The licensee had failed to ensure that on every shift, symptoms indicating the presence of infection in resident #008, #009, and #010 were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing

practices. [s. 229. (5) (a)]

Additional Required Actions:

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

Issued on this 22nd day of October, 2018

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) :	ALICIA MARLATT (590), CASSANDRA TAYLOR (725)
Inspection No. / No de l'inspection :	2018_532590_0019
Log No. / No de registre :	012928-18, 012932-18, 012935-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 22, 2018
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village at St. Clair 1800 Talbot Road, WINDSOR, ON, N9H-0E3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Julie D'Alessandro

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_563670_0003, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required.
O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must be compliant with r. 229 (5) of the Regulation.

Specifically, the licensee must ensure that on every shift, symptoms indicating the presence of infection in residents are monitored, the symptoms are recorded and that immediate action is taken as required.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #003 from inspection #2018_563670_0003 served on May 24, 2018, with a compliance date of July 23, 2018.

The licensee was ordered to be compliant with r. 229. (5) of the Regulation. Specifically the licensee must ensure that on every shift, symptoms indicating the presence of infection in residents are monitored, the symptoms are recorded and that immediate action is taken as required.

The licensee failed to complete monitoring of infections, the recording of symptoms and to ensure that immediate action was taken as required.

A) The licensee had failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Resident #010 was identified as having symptoms of an infection over an identified time period in 2018.

The home noted the illness on the first day, and documented the resident's symptoms. The home notified the Nurse Practitioner (NP) the following day and received telephone orders for a 10 day antibiotic treatment. The following day, resident #010 was assessed by the Physician.

Review of the clinical record for resident #010 showed that the resident had not been monitored related to their infection for 17 percent of the time they were ill.

Review of the surveillance document for the identified unit and time frame showed that resident #010 was added to the list on a specific day, though it was a onetime documentation of symptoms with no assessment or follow-up indication.

During an interview on October 11, 2018, Assistant Director of Care (ADOC) #101 confirmed that no documentation was completed for resident #010 on the identified dates.

Review of the homes policy titled "Infection Control Surveillance "Tab 01-02 indicated that staff were to document on every shift.

B) Resident #009 was identified as having had an infection over an identified time period in 2018. On the first day it was noted in a progress note that symptoms were observed.

The home noted the illness on a specific day, and notified the physician of the illness. The physician assessed resident #009 on that day and ordered a 7 day cycle of antibiotics.

Review of the clinical record for resident #009 showed that the resident had not been monitored related to their infection for 8 percent of the time they were ill.

Review of the surveillance document for the identified unit and time frame, showed that resident #009 was added to the list on the first day of illness, though it was a onetime documentation of symptoms with no assessment or

follow-up indication.

During an interview on October 11, 2018, Assistant Director of Care (ADOC) #101 confirmed that no documentation was completed for resident #009 on the noted shifts and should have been.

C) Resident #008 was identified as having had an infection over an 19 day identified time period in 2018.

On the first day of illness, it was noted in a progress note that the resident was displaying specific infectious symptoms. The nurse practitioner assessed resident #008 the second day and no orders were received at that time.

Four days later, resident #008 had an increase in the display of their symptoms. The physician assessed resident #008 on the fourth day of illness, and orders were given for a 10 day cycle of antibiotics.

Review of the clinical record for resident #073 showed that the resident had not been monitored related to their infection for 18 percent of the time they were ill.

Review of the August 2018, unit surveillance document showed that resident #008 was added to the list on a specific day, though it was a onetime documentation of symptoms with no assessment or follow-up indication.

During an interview on October 11, 2018, Assistant Director of Care (ADOC) #101 stated it was the expectation that residents exhibiting signs and symptoms of infections would be assessed and documentation completed every shift. ADOC #101 indicated that documentation occurred on the surveillance sheet and in PCC. On review of the surveillance sheet ADOC #101 acknowledged that it did not meet the regulations regarding documentation for infection control and that staff had not documented the monitoring on every shift.

The licensee had failed to ensure that on every shift, symptoms indicating the presence of infection in resident #008, #009, and #010 were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The severity of this issue was a level 2 as there was potential for actual harm to the residents. The scope of this issue was a level 2 during the course of the

inspection as residents on multiple units were not monitored. Compliance history was a level 4 as they had on-going non-compliance with this section of the Regulations that included:
- Compliance order (CO) #003 made under r. 229. (5) of the Regulations, was issued on May 24, 2018, with a compliance due date of July 23, 2018 (2018_563670_0003).

(725)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2018

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 22nd day of October, 2018

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 : Alicia Marlatt

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