Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 19, 2020	2020_533115_0014	004299-20, 004301-20, 004682-20, 005028-20, 005030-20, 005474-20, 009217-20, 009444-20, 009624-20, 009735-20, 010529-20, 010559-20, 010753-20, 011475-20, 011585-20, 011967-20	Critical Incident System

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

TERRI DALY (115), CASSANDRA TAYLOR (725), DEBRA CHURCHER (670)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 13, 14, 15, 16, 17, 20 and 21, 2020.

The following Critical Incident inspections were conducted:
Related to falls prevention:
Critical Incident Log #004301-20 / 3046-000017-20
Critical Incident Log #004682-20 / 3046-000019-20
Critical Incident Log #005474-20 / 3046-000023-20
Critical Incident Log #009444-20 / 3046-000031-20
Critical Incident Log #009624-20 / 3046-000032-20
Critical Incident Log #011585-20 / 3046-000042-20
Critical Incident Log #011967-20 / 3046-000043-20

Related to alleged resident to resident abuse:
Critical Incident Log #009217-20 / 3046-000033-20
Critical Incident Log #009735-20 / 3046-000034-20
Critical Incident Log #011475-20 / 3046-000040-20

Related to alleged staff to resident abuse/neglect:
Critical Incident Log #004299-20 / 3046-000016-20
Critical Incident Log #005028-20 / 3046-000020-20
Critical Incident Log #005030-20 / 3046-000021-20
Critical Incident Log #010529-20 / 3046-000036-20
Critical Incident Log #010559-20 / 3046-000037-20

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Nursing, Assistant Director(s) of Nursing, Registered Practical Nurses, Personal Support Workers, Neighbourhood Coordinators, a Kinesiologist, Housekeeping Aides, the Environmental Services Manager, Physiotherapy Assistants and residents.

The inspector(s) also made observations of residents, resident and staff interactions and care and services. Reviewed relevant policies and procedures, as well as clinical records, investigative notes and plans of care for identified residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **5 WN(s)**
- **4 VPC(s)**
- **1 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	Légende 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. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for

addressing incidents of lingering offensive odours.

During an inspection a lingering offensive odour was noted, upon the inspector entering the Colchester Neighbourhood from the stair well. The odour was noted to be strongest down the 1st hallway closest to the nursing station and in the lounge directly across from the nursing station.

A Personal Support Worker(PSW) was seated at the nursing station and was asked if the neighbourhood always smelled like this, they responded saying yes but that it is particularly bad today as the carpets were just cleaned. The PSW explained that there are a few residents on the neighbourhood that express identified behaviours which contributes to the odour. The PSW revealed that interventions had been trialled, but the interventions for these residents' behaviours were not very successful.

An interview with a Housekeeping Aide indicated that they had just cleaned the carpet using specialized products to neutralize the odour. When asked, the staff indicated that they believed there was a process in place to address the odours but that it did not seem to be working on this unit no matter how often they cleaned the carpets.

An interview with the Environmental Services Manager (ESM), they indicated that they were aware of the on going odour but that it should subside when the carpet dries. The ESM provided a copy of the policy related to odours.

A review of the home's policy was completed.
SUBJECT: Odour Control

POLICY: It is the policy of Schlegel Villages to prevent offensive odours where possible and to identify and address incidents of offensive odours that cannot be prevented.

The lingering offensive odour was noted throughout the inspection on the Colchester Neighbourhood on four separate days. An odour was also noted on the Essex Neighbourhood on one occasion however the odour seemed to subside and was not present the following day.

During an interview with the General Manager(GM) they indicated and provided an email that the home had contacted a janitorial company, to come in and professionally clean the carpets on two neighbourhoods which included Colchester. The email response indicated that the company would be available to complete the cleaning in a few weeks.

The GM acknowledged that the odour remained despite the effort of the staff to clean and eliminate the odour and that it should be addressed. [s. 87. (2) (d)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

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

The home submitted a Critical Incident System (CIS) report involving a resident who had had a recent change to their transfer status.

The CIS report also stated that a Registered Practical Nurse (RPN) that was walking down the hall to administer medications to another resident had observed this resident. As the RPN continued down the hallway they heard a noise and found that the resident had fallen.

This resident's plan of care on a specific date noted the resident's specific transfer and ambulation status.

During an interview with the Director of Care (DOC) they stated that the RPN should have intervened when they observed the resident. The DOC acknowledged that the plan of care was not followed.

The licensee failed to ensure that the care set out in the plan of care for this resident was provided to the resident as specified in the plan. [s. 6. (7)]

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

The After Hours (AH) Infoline (IL) was contacted on a specific date, and a Critical Incident System (CIS) report was submitted to the Ministry of Long Term Care (MLTC). Information contained within the report indicated that a resident had a falling incident resulting in injury.

Review of the documentation in Point Click Care (PCC), this resident was identified as a falls risk. Documentation within PCC indicated that the residents interventions were reviewed and a Personal Assistive Service Device (PASD) was planned.

During staff interviews a Personal Support Worker (PSW) and Neighbourhood Coordinator (NC) both indicated that the resident was a falls risk.

During an interview with the Kinesiologist it was indicated that the PASD was ordered, and delivery was taking longer than usual. Electronic mail correspondence was provided and indicated that the PASD was ordered and was delivered to the home and installed on a specific date. The Kinesiologist indicated that no other interventions were initiated while waiting for the PASD.

The licensee failed to ensure that when the resident's plan of care was being revised because care set out in the plan was not been effective, the licensee failed to ensure that different approaches were considered in the revision of the plan of care. [s. 6. (11) (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 care set out in the plan of care was provided to the resident as specified in the plan and to ensure that when a resident is reassessed and the plan of care reviewed and revised, (b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: 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 the resident was protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

On a specific date the After Hours (AH) Infoline (IL) was contacted and a Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC). Information within the report contained allegations of resident to resident abuse.

Review of the relevant documentation in Point Click Care (PCC), showed that two residents had had a previous incident days prior to the report, staff intervened and there was no injury reported. Days later the one resident was discovered by a Personal Support Worker (PSW) to be engaged in an incident with the other resident. The residents were separated, neither resident had any long standing injuries from the incident.

During an interview with the Director of Nursing Care (DOC) it was confirmed that an

incident of this nature would be considered abuse.

The licensee failed to protect a resident from abuse by another resident. [s. 19. (1)]

2. The licensee has failed to ensure that the resident was protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

On a specific date a Critical Incident Systems (CIS) report was submitted to the Ministry of Long-term Care (MLTC) by the home with allegations of resident to resident abuse between two residents.

Review of the relevant documentation in the Point Click Care (PCC) progress notes documented that one resident had reported the incident to the Registered Practical Nurse (RPN).

During a resident interview, this resident described their account of the incident outlined above in detail, confirming the incident.

During a staff interview with the Assistant Director's of Nursing Care (ADNC) and with the Director of Care (DOC) they both indicated that this incident would be considered abuse.

The licensee failed to ensure that a resident was protected from abuse by another resident. [s. 19. (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 residents are protected from abuse by anyone and ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that improper or incompetent treatment or care of resident's that resulted in harm or risk of harm shall immediately report the suspicion and the information upon which it is based to the Director.

The home submitted a Critical Incident System (CIS) report related to suspected neglect of three residents. The CIS report was submitted one day after the incident occurred.

A review of the homes internal investigation notes showed that during the morning of the incident it was reported to the Registered Practical Nurse (RPN). The incident was reported to Neighbourhood Coordinator (NC) that same day.

During an interview with the NC, they stated that they had been off work the day the incident occurred. They stated that the RPN had sent an internal telephone text message to them, but that they did not receive the message until a day after the incident. Upon receiving the message the NC contacted the management of the home to report the contents of the message. The NC stated that the process in the home was to notify the RPN team lead on the unit the day the incident occurred on and they would notify the Charge Nurse. The Charge Nurse would notify management if they were in the building and if it was after hours they would contact the manager on call.

During an interview with the DOC they acknowledged that the home should have reported immediately on the day of the incident, and did not.

The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. [s. 24. (1)]

2. The licensee has failed to ensure that any person who had reasonable grounds to suspect that improper or incompetent treatment or care of six residents that resulted in harm or risk of harm shall immediately report the suspicion and the information upon which it is based to the Director.

The home submitted a Critical Incident System (CIS) report related to suspected neglect of the six residents. The CIS report was submitted three days after the incident occurred.

Review of the homes internal investigation notes showed that during the morning of a specific day, it was reported to the Registered Practical Nurse (RPN) on the floor that six residents had been found in a certain state. The incident was reported to Neighbourhood Coordinator (NC) one day later.

During an interview with the NC, they stated that they had been informed of the concern a day after it was found. The NC stated that the process in the home was to notify the RPN team lead on the unit the day the incident occurred on and they would notify the Charge Nurse. The Charge Nurse would notify management if they were in the building and if it was after hours they would contact the manager on call. The NC stated that they did not know why a CIS was not put in on the day the incident was found, but that it should have been.

During an interview with the DOC they acknowledged that the home should have reported immediately, and did not.

The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. [s. 24. (1)]

3. The licensee has failed to ensured that a person who has reasonable grounds to suspect that the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

On a specific date a Critical Incident Systems (CIS) report was submitted to the Ministry of Health and Long-Term Care (MLTC). Details within the report alleged resident to resident abuse between two residents.

After a review of the documentation contained both within the CIS report and progress notes the incident had occurred two days earlier. The incident was reported to the Registered Practical Nurse (RPN) by the resident who alleged a incident of abuse by another resident.

During an interview with the Assistant Director of Nursing Care (ADNC) it was confirmed that the incident was reported to staff but not reported to the Director immediately.

The licensee failed to ensure that the alleged abuse of a resident was immediately reported to the Director. [s. 24. (1)]

4. The licensee has failed to ensure that a person who has reasonable grounds to suspect that the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

On a specific date, a Critical Incident Systems (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) by the home with allegations of resident to resident abuse between two resident's of an incident that had occurred on a certain date.

Review of the relevant documentation within the Point Click Care (PCC) progress notes showed documentation that one resident reported the incident to the Registered Practical Nurse (RPN) on that date.

During an interview with Assistant Director of Nursing Care (ADNC) it was stated that the incident was reported to the RPN and documented in PCC on that date and not reported

to the MLTC. Upon return to work the ADNC was reading the weekend report an noted the incident and submitted a CIS report to the MLTC two days later.

During staff interviews with Personal Support Worker (PSW), RPN, ADNCs' and the Director of Care (DOC), all indicated that an incident of abuse should be reported immediately. The DOC confirmed the alleged abuse was not reported to the Director immediately.

The licensee failed to ensure that the alleged abuse of a resident was immediately reported to the Director. [s. 24. (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 any person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

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

On a specific date, the After Hours (AH) Infoline (IL) was phoned and the following day a Critical Incident Systems (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC). The information provided alleged an incident of resident to resident physical abuse.

Review of the Point Click Care (PCC) progress notes indicated that two residents had had a previous altercation, no injuries were documented. Upon further review of the documentation there were no interventions implemented to respond to one of the resident's responsive behaviours.

During an interview with the Assistant Director of Nursing Care (ADNC) it was stated that after the incident on that date, interventions were initiated. The ADNC stated that this information was documented on the 24-hour report and carried over daily. Upon further review the ADNC had stated that the 24-hour report records had been discarded.

On review of the documentation no record of the interventions could be found or produced.

During staff interviews related to one of the resident's behaviours, staff did not communicate the intervention.

During an interview with the Director of Care (DOC) the care plan of one of the residents was reviewed and no documentation was found relating to interventions after the incident.

The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between two residents'. [s. 54. (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 steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, (b) identifying and implementing interventions, to be implemented voluntarily.

Issued on this 27th day of August, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	TERRI DALY (115), CASSANDRA TAYLOR (725), DEBRA CHURCHER (670)
Inspection No. / No de l’inspection :	2020_533115_0014
Log No. / No de registre :	004299-20, 004301-20, 004682-20, 005028-20, 005030-20, 005474-20, 009217-20, 009444-20, 009624-20, 009735-20, 010529-20, 010559-20, 010753-20, 011475-20, 011585-20, 011967-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 19, 2020
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
	Tammy Roberts

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Administrator / Nom de l'administratrice ou de l'administrateur :

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 Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The Licensee must implement appropriate corrective actions, to achieve compliance with the LTCHA, 2007 O. Reg. 79/10, s. 87 (2) (d) in addressing incidents of lingering offensive odours.

A corrective solution must be achieved for compliance in addressing incidents of lingering offensive odours on the Colchester neighbourhood.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

During an inspection a lingering offensive odour was noted, upon the inspector

entering the Colchester Neighbourhood from the stair well. The odour was noted to be strongest down the 1st hallway closest to the nursing station and in the lounge directly across from the nursing station.

A Personal Support Worker(PSW) was seated at the nursing station and was asked if the neighbourhood always smelled like this, they responded saying yes but that it is particularly bad today as the carpets were just cleaned. The PSW explained that there are a few residents on the neighbourhood that express identified behaviours which contributes to the odour. The PSW revealed that interventions had been trialled, but the interventions for these residents' behaviours were not very successful.

An interview with a Housekeeping Aide indicated that they had just cleaned the carpet using specialized products to neutralize the odour. When asked, the staff indicated that they believed there was a process in place to address the odours but that it did not seem to be working on this unit no matter how often they cleaned the carpets.

An interview with the Environmental Services Manager (ESM), they indicated that they were aware of the on going odour but that it should subside when the carpet dries. The ESM provided a copy of the policy related to odours.

A review of the home's policy was completed.
SUBJECT: Odour Control

POLICY: It is the policy of Schlegel Villages to prevent offensive odours where possible and to identify and address incidents of offensive odours that cannot be prevented.

The lingering offensive odour was noted throughout the inspection on the Colchester Neighbourhood on four separate days. An odour was also noted on the Essex Neighbourhood on one occasion however the odour seemed to subside and was not present the following day.

During an interview with the General Manager(GM) they indicated and provided an email that the home had contacted a janitorial company, to come in and professionally clean the carpets on two neighbourhoods which included

Colchester. The email response indicated that the company would be available to complete the cleaning in a few weeks.
The GM acknowledged that the odour remained despite the effort of the staff to clean and eliminate the odour and that it should be addressed.

The severity of this issue was determined to be a level 2 - Minimal Harm OR Minimal Risk. The scope of the issue was a level 3 - Widespread as it affects all the residents on the Colchester Neighbourhood. The home had a level 1 no history of non-compliance with this section.

(115)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 21, 2020

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 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 19th day of August, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TERRI DALY

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