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 # / Registre no	Type of Inspection / Genre d'inspection
Feb 24, 2017	2016_262523_0041	031085-16	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

The Village at University Gates
250 Laurelwood Drive WATERLOO ON 000 000

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

ALI NASSER (523), CAROLEE MILLINER (144), JANETM EVANS (659), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 21, 22, 23, 24, 25, 28, 29, 30, December 1 and 2, 2016.

The following Critical Incident inspection was completed during this inspection: Log # 027518-16 / CI 3048-000021-16 related to resident to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with General Manager (GM), Director of Nursing (DON), Assistant Director of Nursing (ADON), Director of Environmental Services (DES), Neighbourhood Coordinator (NC), Registered Dietitian (RD), two RAI-MDS Coordinators, Kinesiologist, Physician, Director of Recreation (DOR), two Laundry Aides, 22 Personal Support Workers (PSW), 19 Registered Staff members, Resident and Family Councils members, three family members and 40 residents.

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

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **20 WN(s)**
- **14 VPC(s)**
- **3 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 a resident was protected from abuse by anyone.

Clinical record review for specific residents stated that from admission and until a certain period of time those residents were exhibiting a certain responsive behaviours toward staff, visitors and each other. On a certain date these two residents had an altercation that resulted in an incident and injury of one of those residents, this resident passed away at a later date.

Specific staff members acknowledged that the Behavioural Support Ontario team of the home were not involved when residents' responsive behaviours were first identified.

A staff member said in an interview that the home had been normalizing residents' responsive behaviour and that they failed to intervene between residents and did not ensure the resident was safe.

During this inspection this non-compliance was found to have a severity level of actual harm/risk, the scope was isolated and there was no previous non compliance in this area. [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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Clinical record review for a certain resident, review of the home's Head Injury Routine policy and staff interviews showed that the home's policy was not complied with by the staff when they did not complete all the post fall assessments and checks.
This resident passed away in the hospital at a later date.

A certain staff member acknowledged that the expectation was that the policy be complied with by the staff.

During this inspection this non-compliance was found to have a severity level of actual harm/risk, the scope was isolated and there was no previous non-compliance in this area. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Clinical record review for certain residents, review of the home's policy titled Weight and Height Monitoring, Nutritional Care and Referrals Registered Dietitian and staff interviews showed that staff did not comply with the home's policy by not reweighing residents and referring to a Registered Dietitian (RD) as per policy.

Certain staff members acknowledged that the staff did not reweigh certain residents and refer certain residents to the RD as per policy. They said that the home's expectation was to have all staff comply with its policies and procedures.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was a pattern and there was no previous non-compliance in this area. [s. 8. (1) (b)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Clinical record review for certain residents, a review of the home's policy titled Incident

Report and staff interviews showed that the staff did not comply with the home's policy by not completing the assessments as per the home's policy and not documenting all information related to incidents as per policy.

A certain staff member acknowledged that the staff did not comply with the home's policy and said that it was the home's expectation to have all staff comply with it's policy.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was a pattern and there was no previous non-compliance in this area. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record was established, maintained and kept in the home in which information was recorded in respect of every drug that was ordered and received in the home.

A review of the drug record re-order book and staff interviews showed that at a certain period of time more than 77 per cent of the drugs ordered did not have a signature of the person acknowledging the receipt of the drug on behalf of the home and the date the drug was received in the home.
A certain staff member stated in an interview that it was their expectation that the registered staff document both their signature and the date on the drug re-order sheets when the drugs were received at the home.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was widespread and there was no previous non-compliance in this area. [s. 133.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

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

Clinical record review for a specific resident, resident observations and staff interviews showed that the plan of care did not set out clear direction to staff specific to a certain aspect of care.

A certain staff member stated that it was the home's expectation that the plan of care set out clear directions to staff who provide direct care to the resident.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was isolated and there was a previous non-

compliance in a similar area. [s. 6. (1) (c)] (532)

2. The licensee has failed to ensure that the staff and others involved in different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Clinical record review for a specific resident and staff interviews showed that staff did not collaborate with each other in the development and implementation of a certain aspect of the plan of care for this specific resident.

During an interview a certain staff member acknowledged the above information and said that it was the home’s expectation that staff collaborate with each other in the development and implementation of the plan of care.
During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was isolated and there was a previous non-compliance in a similar area. [s. 6. (4) (a)]

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

Clinical record review for a specific resident and staff interviews indicated that the plan of care was not revised after this resident continued to express specific symptoms.

A certain staff member said in an interview that different approaches to those specific symptoms were not trialed or considered in the revision of the plan of care.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was isolated and there was a previous non-compliance in a similar area. [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 staff and others involved in different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.
The plan of care sets out clear directions to staff and others who provide direct care to the resident.
The resident is reassessed and the plan of care is being revised because care set out in the plan has not been effective, and different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #5: 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 were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Clinical record review for a certain resident and staff interviews showed that resident had an incident which involved the bed system at a certain period of time.
A certain staff member acknowledged in an interview that the resident was not assessed and their bed system was not evaluated in response to the above incident.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was isolated and there was no previous non-compliance in this area. [s. 15. (1) (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 where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents at a minimum shall:
Provide for a program, that complies with the regulations, for preventing abuse and neglect;
Contain an explanation of the duty under section 24 of the Act to make mandatory reports;
Contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
Set out the consequences for those who abuse or neglect residents;
Comply with any requirements respecting the matters provided for in the regulations.

A review of the home's policy subject: Prevention of Abuse in Long-Term Care and staff interview showed that the home's policy was not in compliance with the LTCHA and regulations.

A certain staff member acknowledged that the home's policy and procedures were not in compliance with the LTCA and Regulation and stated that the home has been working on revising and updating the policy.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was isolated and there was no previous non-compliance in this area. [s. 20. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure, at a minimum, that the policy to promote zero tolerance of abuse and neglect of residents shall:
Provide for a program, that complies with the regulations, for preventing abuse and neglect.
Contain an explanation of the duty under section 24 of the Act to make mandatory reports.
Contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.
Set out the consequences for those who abuse or neglect residents.
Comply with any requirements respecting the matters provided for in the regulations, to be implemented voluntarily.

WN #7: 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 the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A staff interview and a review of certain Internal Incident Reports completed on certain dates and involving identified residents showed that the incidents were identified as a certain type of alleged abuse.

A certain staff member acknowledged that those incidents were not reported to the director and said that the team was working on changing that to ensure that every suspicion of abuse will be identified and reported.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was isolated and there was no previous non-compliance in this area. [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 the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #8: 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:
9. Disease diagnosis. 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 the resident's plan of care was based on an interdisciplinary assessment with respect to the resident's disease diagnosis.

Clinical record review for a specific resident and staff interviews showed that the resident had a specific diagnosis. The resident was expressing symptoms related to this diagnosis. The plan of care had no interventions for this specific diagnosis.

A certain staff member acknowledged the above information and said that it was their expectation that the resident's plan of care would be based on an interdisciplinary assessment with respect to the resident's disease diagnosis.
During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was isolated and there was a previous non-compliance issued in a similar area. [s. 26. (3) 9.]

2. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

Clinical record review for a specific resident and staff interviews showed that resident had a certain skin condition. The plan of care had no interventions with respect to the specific skin condition.
A certain staff member acknowledged that there was no care plan with respect to the resident's skin condition and it was their expectation that the plan of care be based an interdisciplinary assessment with respect to the resident's skin condition.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was isolated and there was a previous non-compliance issued in this area. [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 the plan of care was:
Based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.
Based on an interdisciplinary assessment with respect to the resident's disease diagnosis, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 29. Every licensee of a long-term care home shall ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and, if required, revised. O. Reg. 79/10, s. 29.

Findings/Faits saillants :

1. The licensee had failed to ensure that when a resident was assessed and the resident's plan of care was reviewed, any consent or directive with respect to treatment as defined in the Healthcare Consent Act, 1996, including a consent or directive with respect to a course of treatment or a plan of treatment under the Act, that is relevant, is reviewed and, if required, revised.

Clinical record review for a specific resident and staff interview showed that certain aspect or care and treatment were not revised by the attending physician.
A certain staff member stated that those aspects of care and treatments should have been reviewed with each of the physician's medication and treatment reviews.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was isolated and there was a previous non-compliance issued in a similar area. [s. 29.]

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 when a resident was assessed and the resident's plan of care was reviewed, any consent or directive with respect to "treatment" as defined in the Healthcare Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under the Act, that is relevant, is reviewed and, if required, revised, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents had their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

Observations of certain common areas on certain dates of the inspection showed a certain number of unlabelled personal care items.
Certain staff members acknowledged that those items were not labelled and that those items should have been removed from the common areas.

During this inspection this non-compliance was found to have a severity level of minimal risk, the scope was a pattern and there was no previous non-compliance issued in this area. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident have their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #11: 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. (1) The skin and wound care program must, at a minimum, provide for the following:
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids. O. Reg. 79/10, s. 50 (1).

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 program provided strategies for transferring and positioning residents to reduce pressure and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

A review of the home's Wound care/skin care policy and staff interviews showed that the policy did not for strategies for the prevention of skin breakdown and how to reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

A certain staff member acknowledged that the policy did not mention under prevention of skin breakdown concerning the products used to relieve pressure, including the use of equipment, supplies, devices and positioning aids.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was isolated and there was no previous non-compliance issued in this area. [s. 50. (1) 3.] (532)

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

Clinical record review for a specific resident and staff interviews showed that the resident had an altered skin integrity.

A certain staff member acknowledged that the weekly assessments were not completed on the identified altered skin integrity concern.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was isolated and there was no previous non-compliance issued in this area. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that :
The resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff.

The skin and wound program would provide strategies for transferring and positioning residents to reduce pressure and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home's nutrition care and hydration program was followed with respect to their weight monitoring system.

Clinical record review for certain residents, a review of the home's Weight and Height Monitoring policy and staff interviews showed that the weight for certain residents was not taken as per policy.

A certain staff member acknowledged the above information and stated that it was their expectations that the weights be taken and recorded as per the home's nutrition care and hydration program.

During this inspection this non-compliance was found to have a severity level of minimum risk, the scope was a pattern and there was no previous non-compliance issued in this area. [s. 68. (2) (e) (ii)]

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 weight of each resident is measured on admission and monthly thereafter, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that one resident with a weight change of 5 per cent of body weight, or more, over one month was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

A clinical record review for a specific resident, a review of the home's Weight and Height Monitoring policy a review of the home's policy Nutritional Care and Referrals and staff interviews showed that that the resident had a change in weight at a certain period of time, the resident was not reweighed and a referral to the Registered Dietitian (RD) was not initiated.

A certain staff member acknowledged that this resident was not re-weighed and a referral to the RD was not completed.
A certain staff member stated it was their expectation that the resident would have been re-weighed and a referral to the RD would have been completed as necessary.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm/risk, the scope was isolated and there was no previous non-compliance issued in this area. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 one resident with a weight change of 5 per cent of body weight, or more, over once month was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

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

A review of the home's training record related to the annual training of the licensee's abuse prevention policy showed that 91% of staff had completed the training.

A certain staff member acknowledged the above information and state that the expectation was that all staff would complete the training annually.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm/risk, the scope was isolated and there was no previous non-compliance issued in this area. [s. 76. (4)]

Additional Required Actions:

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

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every year, a survey was taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

A review of the Long Term Care Homes (LTCH) Licensee Confirmation Checklist for Quality Improvement and Required Programs and staff interviews showed that the home did not complete the satisfaction surveys.
A certain staff member acknowledged awareness that a satisfaction survey should be completed at least once every year with residents and their families and stated that a resident satisfaction survey had not been completed by the home within the last year, they said that they are in the process of completing a survey very soon.

During this inspection this non-compliance was found to have a severity level of minimum harm, the scope was widespread and there was no previous non-compliance issued in this area. [s. 85. (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 at least once in every year, a survey was taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of laundry services procedures were implemented to ensure that there was a process to report and locate residents' lost clothing.

At a certain date of the inspection specific residents said that they had lost cloths in the last year, the home was not been able to locate the residents' lost clothing.

Staff interviews a review of the log book for missing items showed that the home had recently starting implementing its process related to missing items.

Staff members acknowledged that at the time those items went missing the home was not implementing their own process for reporting and locating residents' lost clothing.

During this inspection this non-compliance was found to have a severity level of minimum harm, the scope was a pattern and there was no previous non-compliance issued in this area. [s. 89. (1) (a) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the organized program of laundry services procedures are implemented to ensure that there is a process to report and locate residents' lost clothing, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

At a certain date and time during this inspection hazardous substances were observed to be unattended and accessible to nearby residents.

Two staff members acknowledged that hazardous substances were accessible to residents and stated in interviews that the home's expectation was to keep hazardous substances inaccessible to residents.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm/risk, the scope was isolated and there was no previous non-compliance issued in this area. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home were kept inaccessible to residents at all times, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they fully respected and promoted the resident's right to be treated with courtesy and respect in a way that fully recognized their individuality and respected their dignity.

Clinical record review for a specific resident, resident and staff interviews showed that the home had taken a specific items away from the resident as a result of a certain action performed by the resident. Staff also entered the resident's room and searched for a certain items on several occasions, at times without their permission and at other times they were informed but in presence of other residents.

The licensee failed to fully respect and promote the resident's right to be treated with courtesy and respect in a way that fully recognized their individuality and respected their dignity.

During this inspection this non-compliance was found to have a severity level of minimum harm, the scope was isolated and there was a previous non-compliance issued in a similar area. [s. 3. (1) 1.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A record review of the staffing plan and staff interview showed no record of an annual evaluation that was completed to evaluate the staffing plan in accordance with evidence based practices and if there were none in accordance with prevailing practices.

A certain staff member acknowledged that the staffing plan's annual evaluation was not completed.

During this inspection this non-compliance was found to have a severity level of minimum harm, the scope was a pattern and there was no previous non-compliance issued in this area. [s. 31. (3)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. The licensee has failed to ensure that tracking and documentation with respect to the emergency drug supply was maintained.

A review of the home's Emergency Stock Box policy, observations at a certain date of the inspection and staff interviews showed that the tracking and documentation with respect to the emergency drug supply was not maintained and the inventory of the medications in the emergency box was not monitored.

A certain staff member said that the Home and pharmacy should have completed monthly inventories on the emergency medication stock box and that the missing medications should have been treated by registered staff as a medication incident.

During this inspection this non-compliance was found to have a severity level of minimum harm, the scope was isolated and there was no previous non-compliance issued in this area. [s. 123. (b)]

Issued on this 27th day of February, 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), CAROLEE MILLINER (144), JANETM EVANS (659), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2016_262523_0041
Log No. / Registre no:	031085-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 24, 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 at University Gates 250 Laurelwood Drive, WATERLOO, ON, 000-000
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chris-Anne Preston

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

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

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

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was protected from abuse by anyone.

Clinical record review for specific residents stated that from admission and until a certain period of time those residents were exhibiting a certain responsive behaviours toward staff, visitors and each other. On a certain date these two residents had an altercation that resulted in an incident and injury of one of those residents, this resident passed away at a later date.

Specific staff members acknowledged that the Behavioural Support Ontario team of the home were not involved when residents' responsive behaviours were first identified.

A staff member said in an interview that the home had been normalizing residents' responsive behaviour and that they failed to intervene between residents and did not ensure the resident was safe.

During this inspection this non-compliance was found to have a severity level of actual harm/risk, the scope was isolated and there was no previous non compliance in this area. [s. 19. (1)] (523)

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the following policies and procedures are complied with:

Head Injury Routine.
Weight and Weight Monitoring.
Nutritional Care and Referrals-Registered Dietitian.
Incident Reports.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Clinical record review for a certain resident, review of the home's Head Injury Routine policy and staff interviews showed that the home's policy was not complied with by the staff when they did not complete all the post fall assessments and checks.
This resident passed away in the hospital at a later date.

A certain staff member acknowledged that the expectation was that the policy be complied with by the staff.

During this inspection this non-compliance was found to have a severity level of actual harm/risk, the scope was isolated and there was no previous non-

compliance in this area. [s. 8. (1) (a),s. 8. (1) (b)] (532)

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Clinical record review for certain residents, review of the home's policy titled Weight and Height Monitoring, Nutritional Care and Referrals Registered Dietitian and staff interviews showed that staff did not comply with the home's policy by not reweighing residents and referring to a Registered Dietitian (RD) as per policy.

Certain staff members acknowledged that the staff did not reweigh certain residents and refer certain residents to the RD as per policy. They said that the home's expectation was to have all staff comply with its policies and procedures.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was a pattern and there was no previous non-compliance in this area. [s. 8. (1) (b)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Clinical record review for certain residents, a review of the home's policy titled Incident Report and staff interviews showed that the staff did not comply with the home's policy by not completing the assessments as per the home's policy and not documenting all information related to incidents as per policy.

A certain staff member acknowledged that the staff did not comply with the home's policy and said that it was the home's expectation to have all staff comply with it's policy.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was a pattern and there was no previous non-compliance in this area. [s. 8. (1) (b)] (523)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 133. Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Order / Ordre :

The licensee shall ensure that a drug record was established, maintained and kept in the home in which information is recorded in respect of every drug that is ordered and received in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that a drug record was established, maintained and kept in the home in which information was recorded in respect of every drug that was ordered and received in the home.

A review of the drug record re-order book and staff interviews showed that at a certain period of time more than 77 per cent of the drugs ordered did not have a signature of the person acknowledging the receipt of the drug on behalf of the home and the date the drug was received in the home.
A certain staff member stated in an interview that it was their expectation that the registered staff document both their signature and the date on the drug re-order sheets when the drugs were received at the home.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm, the scope was widespread and there was no previous non-compliance in this area. [s. 133.] (144)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 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 or by fax upon:

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

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

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 24th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

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