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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 10, 2017	2017_610633_0017	019120-17	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

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

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

SHERRI COOK (633), APRIL TOLENTINO (218), DEBRA CHURCHER (670), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 28-31, September 5-7, 2017.

The following inspections were conducted concurrently during this inspection:
Log #020951-16 / IL-45633-LO- Complaint related to a treatment.
Log #026588-16 / 3048-000018-16- Critical Incident related to alleged abuse.
Log #031636-16 / 3048-000016-16- Critical Incident related to a resident fall.
Log #017632-17 / 3048-000024-17- Critical Incident related to a resident fall.
Log #006491-17 / 3048-000014-17- Critical Incident related to a resident fall and wound care.
Log #008851-17 / 3048-0000016-17- Critical Incident related to a resident fall.
Log #020932-17 / 3048-0000026-17- Critical Incident related to a resident fall.
Log #004883-17 Follow-up to orders from Resident Quality Inspection (RQI) #2016_262523_0041 related to alleged abuse, policies and drug records.
Log #017693-17 / IL-52183-LO- Complaint related to staffing and nutrition care.
Log #005679-17 / IL-49826-LO- Complaint related to a medication.

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Nursing Care, the Assistant Director of Nursing Care, the Director of Recreation, the Assistant Food Services Manager, a Registered Dietician, a Registered Kinesiologist, Registered Nurses, Resident Assessment Instrument Coordinators, a Registered Practical Nurse/Personal Expression Response Team member, Registered Practical Nurses, Personal Support Workers, Personal Care Aides, a Residents' Council member, a Family Council member, family members and 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. Additionally, the inspector(s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
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.

- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 133.	CO #003	2016_262523_0041	532
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_262523_0041	633
O.Reg 79/10 s. 8. (1)	CO #002	2016_262523_0041	633

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. 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).

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC). The CIS stated that a resident sustained an injury from a fall. The CIS further stated that a staff member did not follow the plan of care for the resident.

The home's policy titled "Fall Prevention and Management Program [LTC]" that was not dated stated that the Neighbourhood Team members were to "follow the strategies as outlined in the plan of care" and the team members "will consult the plan of care for specific goals and interventions related to the resident's risk".

A review of the plan of care in PointClickCare (PCC) stated that the resident required a specific intervention prior to the resident's fall. The plan of care also stated that another intervention was required for the resident related to another specific activity of daily living.

The Fall progress note in PointClickCare (PCC) for the resident stated that the resident complained of pain and a specific treatment was provided. The progress notes further stated that an injury was noted and a treatment was ordered.

In an interview with the resident they stated that they were usually left alone for this activity of daily living and that they utilized the call bell for assistance.

The care plan in PCC stated that the resident was still recovering from their injury.

In an interview with the Director of Nursing Care (DONC) they stated that the expectation was that the resident received the required assistance. The DONC further stated that the staff member’s failure to refer to the resident's plan of care contributed to the resident’s fall and the expectation was that staff were to refer to the care plan whenever they were unfamiliar with aspects of the resident’s care.

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

2. A Complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) by the family member of a resident related to concerns with the resident's care and decline.

The physician orders in PCC and the printed electronic Medication Administration Record (eMAR) stated that the resident was to have their weight taken over a specific period of

time. The resident's weight was not completed and documented five times during this period.

During review of the eMAR with Registered Practical Nurse (RPN) / Resident Assessment Instrument Coordinator (RPN/RAI-C) they said that the weights for the resident should have been taken on these days per the physician's orders and were not, there were no progress notes that stated that the resident had declined to have their weight taken and the resident was present in the home and not on a leave of absence (LOA) on these days.

In an interview with Director of Nursing Care (DONC) they agreed that the resident was not weighed per their plan of care and the expectation was that the resident's weights were taken as specified in the physician orders and they were not.

The licensee has failed to ensure that the physician's order for weights set out in their plan of care was provided to a resident as specified in their plan.

The severity of the issue was actual harm/risk, the scope of the issue was isolated and the home had a history of related non-compliance. [s. 6. (7)]

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. 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 each resident of the home had his or her personal items, that included personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

The home's policy titled "Personal Care Ware" last reviewed December 27, 2016, stated that "all personal ware was labeled with resident name and or room number including but not limited to basin, cup, denture cup and personal care products."

During the tour of the home in Stage 1 of the Resident Quality Inspection (RQI) there were various unlabelled personal items observed in specific rooms throughout the home.

In an interview, a Registered Practical Nurse (RPN) stated that all resident's personal items were to be labelled with the resident's initials and /or room number. The RPN also said that a specific personal item was to be stored separately. The RPN acknowledged that the this personal item was not separated.

In an interview with the Director of Nursing Care (DONC) they stated that the expectation was that all resident's personal items were to be labelled with the residents initial and they agreed that this was not followed by staff.

The licensee has failed to ensure that each resident of the home had his or her personal items, that included personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

The severity of the issue was minimal risk, the scope of the issue was widespread and the home had a history of related non-compliance. [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 each resident of the home has his or her 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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols developed for the medication management system were implemented in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The home's policy "8.2, Narcotic and Controlled Medication Destruction", revised March 1, 2016, stated "2. Any narcotic substance to be disposed of must be stored separately from any medication available for administration to a resident. Narcotics that are discontinued must be removed from the narcotic lock box in the locked medication cart and transferred to a separate, secure storage area for narcotic and controlled substances waiting for destruction.”

During a narcotic shift count observation it was noted that narcotic and controlled substances that were discontinued were being counted and kept together in the narcotic lock box with the controlled substances that were available for administration to a resident. It was observed that two resident's had a specific medication that was discontinued and it was kept together with the controlled substances that were available for administration.

A Registered Practical Nurse (RPN) stated that the controlled substances that were discontinued were kept together with medications available for administration and these narcotics were counted until they were picked up by the Director of Nursing Care (DONC). The RPN also stated that the controlled substances for destruction were usually removed within a week but that sometimes they might be stored in the narcotic lock box with medications to be administered to residents longer.

The DONC agreed that the controlled substances/narcotics waiting for destruction were kept together with the narcotic for administration to residents and these medications were counted until they were picked by the DONC or designate.

The licensee has failed to ensure that the written policies and protocols developed for the medication management system related to drug storage and destruction were implemented in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The severity of the issue was minimal harm or potential for actual harm, the scope of the issue was widespread and the home had a history of multiple unrelated non-compliance. [s. 114. (3)]

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 written policies and protocols developed for the medication management system were implemented in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 19th day of October, 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) :	SHERRI COOK (633), APRIL TOLENTINO (218), DEBRA CHURCHER (670), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2017_610633_0017
Log No. / No de registre :	019120-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 10, 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:

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

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to all residents as specified in the plan. Specifically, that the care for a specific resident is provided to the resident as specified in their plan.

Grounds / Motifs :

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

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC). The CIS stated that a resident sustained an injury from a fall. The CIS further stated that a staff member did not follow the plan of care for the resident.

The home's policy titled "Fall Prevention and Management Program [LTC]" that was not dated stated that the Neighbourhood Team members were to "follow the strategies as outlined in the plan of care" and the team members "will consult the plan of care for specific goals and interventions related to the resident's risk".

A review of the plan of care in PointClickCare (PCC) stated that the resident required a specific intervention prior to the resident's fall. The plan of care also stated that another intervention was required for the resident related to another specific activity of daily living.

The Fall progress note in PointClickCare (PCC) for the resident stated that the resident complained of pain and a specific treatment was provided. The progress notes further stated that an injury was noted and a treatment was ordered.

In an interview with the resident they stated that they were usually left alone for this activity of daily living and that they utilized the call bell for assistance.

The care plan in PCC stated that the resident was still recovering from their injury.

In an interview with the Director of Nursing Care (DONC) they stated that the expectation was that the resident received the required assistance. The DONC further stated that the staff member's failure to refer to the resident's plan of care contributed to the resident's fall and the expectation was that staff were to refer to the care plan whenever they were unfamiliar with aspects of the resident's care.

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

(218)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 10th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Sherri Cook

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