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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 11, 2013	2013_232112_0001	L-000218-13	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8

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

CAROLE ALEXANDER (112)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 17, May 07 & 15, 2013

L-000218-13

During the course of the inspection, the inspector(s) spoke with the General Manager, Assistant Director of Care, a Charge Nurse, 3 Registered Practical Nurses, a Housekeeping Aide, a Porter, 8 Personal Support Workers, 5 Family Members and 14 residents

During the course of the inspection, the inspector(s) reviewed policies and procedures related to Infection Control, a job description for clinic portering,and numerous walk throughs of the clinic path were made as well as observations for infection control practices and resident rights.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 not ensured that the home's policies and procedures are complied with as evidenced by the following:

a) On April 17 and May 07, 2013 the home was declared in an outbreak and the Inspector observed patients accessing the clinic located within the Long Term Care Home who did not use hand sanitizer and were not questioned regarding any respiratory symptoms which would dictate the use of appropriate Personal Protective Equipment, as per policy.
On April 17, 2013 the designated porter staff for the clinic patients was not aware of the home's infection control policies and procedures related to monitoring and ensuring hand sanitizer use by all clinic patients upon entry to the long term care home.
b) The home's policy - "Infection Control - Outbreaks - dated Nov 2012" states the following:
"6. The Health Centre may cut down the volume of patients to be seen during the outbreak.
7. Increased screening of all Health Centre patients will be done over the phone"
On April 17, 2013, Management of the home did not ensure that the clinic had screened patients and/or determined the need to decrease the volume of patients scheduled to come in as per their policy.
c) On April 11, 2013, the Licensee received an email stating that family had observed a clinic patient with respiratory symptoms exiting the home through the main entrance instead of the clinic designated entrance/exit. On March 06, 2013 management of the home received an email stating that the clinic physician had been observed to access the clinic without using hand sanitizer and accessed the clinic through the Long Term Care entrance instead of the designated path. [s. 8. (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. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. Management of the home was not able to provide documentation that included time frames and type of actions for resolve to the following complaints received:
- Feb. 11, 2013 - an email asking how the Licensee is ensuring "resident safety, privacy, physical safety and infection control safety" when community persons are entering the home.
- March 06, 2013 - an email stating that the clinic physician is not using the designated pathway and not using hand sanitizer upon entering the building.
- March 13, 2013 - an email asking how the clinic serves to the benefit of residents currently in the home.
- Feb. 19, 2013 - an email stating that a response to concerns expressed on Feb. 11, 2013 have not been responded to and a concern added regarding airborne pathogens and vulnerable residents
- April 11, 2013 - an email stating the home is in current outbreak and that the writer had observed patients who were visibly ill not utilizing the designated pathway to the clinic and were seen exiting through the main entrance. The email states that the Licensee had received correspondence from the Medical Officer stating that in the event of an outbreak the clinic would be closed. This concern also stated the clinic to be a risk to the residents' health and safety and a violation of their quality of life. Families confirm that the above issues have been ongoing, longstanding and repetitive. [s. 101. (2)]

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (8) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and O. Reg. 79/10, s. 229 (8).

Findings/Faits saillants :

1. The Licensee failed to ensure that there was an outbreak management system to manage and control infectious disease outbreak as evidenced by:
The clinic serving community patients continued to operate on the following dates while the home was in outbreak and one elevator was broken down which effected clinic patients, residents and family using one elevator. Dec 14, 2012, April 11, and June 12, 2013
Management was not able to provide evidence of a contingency plan in the event of outbreak, elevator breakdown and clinic operations posing an increased infection control risk to long term care residents. [s. 229. (8) (a)]

Additional Required Actions:

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

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

Issued on this 11th day of July, 2013

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

C. ALEXANDER

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROLE ALEXANDER (112)
Inspection No. / No de l'inspection :	2013_232112_0001
Log No. / Registre no:	L-000218-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 11, 2013
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF RIVERSIDE GLEN 60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	HEATHER CAUWENBERGHE

To OAKWOOD RETIREMENT COMMUNITIES 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 :

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 will ensure that the home's policies and procedures related to infection control are complied with;

Grounds / Motifs :

1. The Licensee has not ensured that the home's policies and procedures are complied with as evidenced by the following:

a) On April 17 and May 07, 2013 the home was declared in an outbreak and the Inspector observed patients accessing the clinic located within the Long Term Care Home who did not use hand sanitizer and were not questioned regarding any respiratory symptoms which would dictate the use of appropriate Personal Protective Equipment, as per policy.
On April 17, 2013 the designated porter staff for the clinic patients was not aware of the home's infection control policies and procedures related to monitoring and ensuring hand sanitizer use by all clinic patients upon entry to the long term care home.
b) The home's policy - "Infection Control - Outbreaks - dated Nov 2012" states the following:
"6. The Health Centre may cut down the volume of patients to be seen during the outbreak.
7. Increased screening of all Health Centre patients will be done over the phone"
On April 17, 2013, Management of the home did not ensure that the clinic had screened patients and/or determined the need to decrease the volume of patients scheduled to come in as per their policy.
c) On April 11, 2013, the Licensee received an email stating that family had observed a clinic patient with respiratory symptoms exiting the home through the main entrance instead of the clinic designated entrance/exit. On March 06, 2013 management of the home received an email stating that the clinic physician had been observed to access the clinic without using hand sanitizer and accessed the clinic through the Long Term Care entrance instead of the designated path.
(112)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2013

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Order / Ordre :

The Licensee shall ensure that a documented record of complaints received include the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant

Grounds / Motifs :

1. Management of the home was not able to provide documentation that included time frames and type of actions for resolve to the following complaints received:
- Feb. 11, 2013 - an email asking how the Licensee is ensuring "resident safety, privacy, physical safety and infection control safety" when community persons are entering the home.
- March 06, 2013 - an email stating that the clinic physician is not using the designated pathway and not using hand sanitizer upon entering the building.
- March 13, 2013 - an email asking how the clinic serves to the benefit of residents currently in the home.
- Feb. 19, 2013 - an email stating that a response to concerns expressed on Feb. 11, 2013 have not been responded to and a concern added regarding airborne pathogens and vulnerable residents
- April 11, 2013 - an email stating the home is in current outbreak and that the writer had observed patients who were visibly ill not utilizing the designated pathway to the clinic and were seen exiting through the main entrance. The email states that the Licensee had received correspondence from the Medical Officer stating that in the event of an outbreak the clinic would be closed. This concern also stated the clinic to be a risk to the residents' health and safety and a violation of their quality of life.
Families confirm that the above issues have been ongoing, longstanding and repetitive.
(112)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2013

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (8) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 79/10, s. 229 (8).

Order / Ordre :

The Licensee shall ensure that there is an outbreak management system that manages and controls infectious disease outbreaks;

Grounds / Motifs :

1. The Licensee failed to ensure that there was an outbreak management system to manage and control infectious disease outbreak as evidenced by:
The clinic serving community patients continued to operate on the following dates while the home was in outbreak and one elevator was broken down which effected clinic patients, residents and family using one elevator. Dec 14, 2012, April 11, and June 12, 2013
Management was not able to provide evidence of a contingency plan in the event of outbreak, elevator breakdown and clinic operations posing an increased infection control risk to long term care residents. (112)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2013

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

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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.

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

Ministère 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

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
Direction de l'amélioration de la performance et de la conformité
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 11th day of July, 2013

Signature of Inspector / Signature de l'inspecteur : C. ALEXANDER

Name of Inspector / Nom de l'inspecteur : CAROLE ALEXANDER

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