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 prévue le Loi de 2007 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
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## Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 05, 2016; | 2016_457630_0029 (A1) | 017016-16, 014960-16 | Follow up |

### Licensee/Titulaire de permis

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

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

THE VILLAGE OF GLENDALE CROSSING
3030 Singleton Avenue LONDON ON N6L 0B6

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

AMIE GIBBS-WARD (630) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**The compliance date for CO#005 has been changed from August 31, 2016, to September 30, 2016, based on request from Licensee.**

**Issued on this 5 day of August 2016 (A1)**

**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**

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3030 Singleton Avenue LONDON ON N6L 0B6

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

AMIE GIBBS-WARD (630) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

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

**This inspection was conducted on the following date(s): July 26, 27 and 28, 2016.**

**This is a follow-up to Log #014960-16, inspection # 2016_262523_0019:**

**CO #001 regarding bed system assessments**

**This is a follow-up to Log #017016-16, inspection # 2016_262523_0016:**

**CO #007 regarding doors leading to non-residential areas**

**CO #011 regarding documented records for complaints in the home**

**CO#012 regarding monitoring and documenting effectiveness medications**

**CO #015 regarding implementation of infection prevention and control program**

**CO#016 regarding immunization and screening measures**

**During the course of the inspection, the inspector(s) spoke with Acting General Manager, Assistant Director of Nursing Care, Support Office-Nurse Consultant, Director of Food Services, Director of Environmental Services, two Neighbourhood Coordinators, one Kinesiologist, one Maintenance Worker, one Registered Nurse, two Registered Practical Nurses, two Personal Care Aides and two Food Service Workers.**

**The inspectors also toured the home, observed the provision of resident care, reviewed relevant clinical records, reviewed policies and procedures and observed resident-staff interactions.**

**The following Inspection Protocols were used during this inspection:**

**Infection Prevention and Control**

**Medication**

**Reporting and Complaints**

**Safe and Secure Home**

**During the course of this inspection, Non-Compliances were issued.**
**7 WN(s)**
**2 VPC(s)**
**5 CO(s)**
**1 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. 229. (4) | CO #015 | 2016_262523_0016 | 630 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 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 are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

This was a follow up to an order that was previously issued on May 16, 2016, under log #014960-16 and inspection #2016_262523_0019 with a compliance order date of May 31, 2016.

The order included that 'The licensee shall ensure residents are reassessed in their bed systems after a change in the system such as a new mattress'.

A clinical record review related to request for bed changes in the home showed changes were made to the bed system for identified residents. Clinical record review revealed that a bed rail assessment was not completed on those beds after the change in beds.

Clinical record review for an identified resident showed that no bed entrapment assessment was completed at admission.

A review of the bed entrapment assessment audit showed that that beds in three identified rooms had failed the Bed Entrapment Audit.

Staff interviews indicated it was the expectation in the home to complete a bed entrapment assessment for new admissions. It was also reported that if the room number was not on the bed entrapment audit then the assessment was not completed. These staff said that if a bed had failed the assessment, the maintenance staff would fix the failing zones and the bed would be reassessed to ensure it was safe. A review of the Bed Entrapment Audit with these staff revealed that beds in identified rooms had no documented record that the entrapment failed zones were fixed or if any reassessments were completed.

During an interview the Acting General Manager (AGM) acknowledged the bed assessments were not completed. AGM said that the compliance order was clear as to what needed to be done and the home did not do it and acknowledged that it would be reissued.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be a pattern. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order. This was previously issued as a Written Notification and Compliance Order on May 16, 2016, under log #014960-16 and inspection #2016_262523_0019 with a compliance order date of May 31, 2016. [s. 15. (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. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

This was a follow up to an order that was previously issued on:
- May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with a compliance order date of June 30, 2016
- December 18, 2015, under log #036514-15 and inspection #2015_183128_0023 with compliance order date of January 15, 2016.

The order stated that 'The licensee shall ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs'.

A clinical record review of a medication report in the home revealed that several pain and antipsychotic medications were given as needed but medication effectiveness was not documented.

The Support Office Nurse Consultant and AGM confirmed that the staff did not document resident response for medications. The AGM reported that the report reflected that the home did not comply with the order.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be a pattern. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order. This was previously issued as a Written Notification and Compliance Order on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with a compliance order date of June 30, 2016. This was previously issued as a Written Notification and Compliance Order on December 18, 2015, under log #036514-15 and inspection #2015_183128_0023 with compliance order date of January 15, 2016. [s. 134. (a)]

***Additional Required Actions:***

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

***DR # 001 – The above written notification is also being referred to the Director for further action by the Director.***

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**WN #3: 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. The licensee has failed to ensure that a documented record was kept in the home for any complaint that included 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, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

This was a follow-up to an order that was previously issued on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with compliance date of June 30, 2016.

The order included that "The licensee shall ensure that a documented record was kept in the home for any complaint that includes 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, every date on which any response is provided to the complainant and a description of the response and any response made in turn by the complainant."

Review of the "Resident/Family Concerns Response Form" for several different verbal and written complaints made to the home showed the documented records of the complaints were incomplete.

During an interview with staff responsible for completing the forms it was reported that since the compliance order had been received by the home they had been more thorough about completing the "Resident/Family Concerns Response Form" documentation in the home. Reviewed the incomplete forms with these identified staff and it was acknowledged that the documentation was incomplete.

During an interview with the AGM it was identified that the management in the home had been working to make improvements in how verbal and written complaints were being documented. AGM reported they had recently revised the "Resident/Family Concerns" policy but the processes remained the same that specified staff were responsible for documenting the complaints and concerns in most cases and then the AGM would review once completed. Reviewed the "Resident/Family Concerns Response Form" with AGM for an identified resident and the AGM acknowledged that the documentation was incomplete and that although the home had made improvements in the process the order was not complied with.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be pattern. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order. This was previously issued as a Written Notification and Compliance Order on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with

compliance date of June 30, 2016. This was previously issued as a Written Notification and Voluntary Plan of Correction on November 24, 2015, under log #031635-15 and inspection #2015_183128_0023. This was previously issued as a Written Notification and Voluntary Plan of Correction on September 9, 2015, under log #024284-15 and inspection #2015_217137_0040. [s. 101. (2)]

***Additional Required Actions:***

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

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**WN #4: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:**
**1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the following immunization and screening measures were in place: each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

This was a follow-up to an order that was previously issued on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with compliance date

of June 30, 2016.

The order included that "The licensee will ensure the following immunization and screening measures are in place: 1. All residents who have already been admitted to the home and have not been screened for tuberculosis are screened immediately. 2. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee."

Review of the home's immunization record revealed there were five out of 190 residents who were already residents of the home, who had no record of Tuberculosis (TB) screening either through a TB skin test or chest x-ray having been completed.

Clinical record review for an identified resident showed that documentation that Tuberculosis (TB) screening either through a TB skin test or chest x-ray had not been completed within 14 days of admission. The record showed a mobile x-ray requisition had been faxed to the company but the x-ray had not been completed at the time of the inspection.

During an interview with Assistant Director of Nursing (ADON) it was identified that the home had been working to ensure the immunization record was up to date for all existing and new residents. ADON reported that they had been trying to offer TB screening to all residents but ran out of the syringes needed to complete the TB skin test and more had been ordered. ADON also reported there were delays between when a chest x-ray was requested for screening and when it was being completed by the company who provided the service to the home. Reviewed the immunization records with ADON and it was acknowledged that there were residents who had not been screened for TB in the home and therefore the order was not complied with.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be isolated. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order. This was previously issued as a Compliance Order on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with compliance date of June 30, 2016. [s. 229. (10) 1.]

***Additional Required Actions:***

**CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

This was a follow up to an order that was previously issued on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with a compliance order date of June 30, 2016.

The order included that 'The licensee shall ensure that all doors leading to non-residential areas are kept locked when they are not being supervised by staff. The licensee shall ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, and shall educate all staff on this policy'.

Observations during this inspection revealed that all doors leading to non-residential areas were kept locked.

An interview with AGM revealed that the Building Safety and Security Policy was updated in May 2016.

A review of the policy with AGM revealed that the policy did not deal with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

A review of the compliance order with the AGM found the policy did not include direction to staff as to when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. AGM said in an interview that the order was not complied with.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be isolated. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order. This was was previously issued as a Compliance Order on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with a compliance order date of June 30, 2016.(523) [s. 9.]

***Additional Required Actions:***

**CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A1)The following order(s) have been amended:CO# 005**

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**WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care**
**Specifically failed to comply with the following:**

**s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

During an interview with a staff member it was reported that the family of an identified resident had expressed concerns about specific aspects of the personal care provided to the resident.

Review of the plan of care for this identified resident showed it did not include direction regarding needs or preferences for the aspects of personal care for which the family member had expressed the concerns.

During an interview with the Acting General Manager (AGM) the plan of care for this identified resident was reviewed and it was acknowledged that it did not provide direction for staff regarding the resident's need and preferences for this aspect of personal care. The AGM reported it was the expectation in the home that the plan of care would include that information.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be isolated. The home has had ongoing non-compliance with this section of the legislation. This was previously issued as a Written Notification and Voluntary Plan of Correction on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016. [s. 6. (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 with ensuring the care set out in the plan of care for continence care is based on the needs and preferences of that resident, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The Licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Over the course of the inspection it was observed on two separate occasions that a staff person placed an unlabeled medication cup which contained narcotics and controlled substances mixed in applesauce into the top drawer of the medication cart. The medication was not placed in a separate locked area within the locked medication cart. The staff person then left the cart to administer medications to another resident. During an interview the staff person acknowledged that narcotic and controlled substances were to be double locked.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be isolated. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order which was complied in July 2016. [s. 129. (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 with ensuring controlled substances are stored in a separate locked area within the locked medication cart, to be implemented voluntarily.***

**Issued on this 5 day of August 2016 (A1)**

**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**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

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


**Long-Term Care Homes Division**
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## Amended Public Copy/Copie modifiée du public de permis

**Name of Inspector (ID #) / Nom de l'inspecteur (No) :** AMIE GIBBS-WARD (630) - (A1)

**Inspection No. / No de l'inspection :** 2016_457630_0029 (A1)

**Appeal/Dir# / Appel/Dir#:**

**Log No. / Registre no. :** 017016-16, 014960-16 (A1)

**Type of Inspection / Genre d'inspection:** Follow up

**Report Date(s) / Date(s) du Rapport :** Aug 05, 2016;(A1)

**Licensee / Titulaire de permis :** Schlegel Villages Inc
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

**LTC Home / Foyer de SLD :** THE VILLAGE OF GLENDALE CROSSING
3030 Singleton Avenue, LONDON, ON, N6L-0B6

**Name of Administrator / Nom de l'administratrice ou de l'administrateur :** MICHELLE VERMEEREN

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

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

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

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**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2016_262523_0019, CO #001;

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(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).

**Order / Ordre :**

The licensee shall ensure four specified residents are reassessed in their bed system.

The licensee shall ensure the bed entrapment failed zones in three specified rooms are fixed and a bed entrapment reassessment completed.

The licensee shall ensure residents are reassessed in their bed systems after a change in the system such as new mattress.

The licensee shall develop and implement an audit to ensure all residents using bed rails are assessed in their bed systems and that all bed systems are assessed in accordance with the legislation. The licensee shall appoint a management or supervisory staff person to complete the audits. This audit will be documented and reviewed with the GM by the compliance date and ongoing on a monthly basis.

Ontario

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

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

**Grounds / Motifs :**

1. The licensee has failed to ensure that where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

This was a follow up to an order that was previously issued on May 16, 2016, under log #014960-16 and inspection #2016_262523_0019 with a compliance order date of May 31, 2016.

The order included that 'The licensee shall ensure residents are reassessed in their bed systems after a change in the system such as a new mattress'.

A clinical record review related to request for bed changes in the home showed changes were made to the bed system for identified residents. Clinical record review revealed that a bed rail assessment was not completed on those beds after the change in beds.

Clinical record review for an identified resident showed that no bed entrapment assessment was completed at admission.

A review of the bed entrapment assessment audit showed that that beds in three identified rooms had failed the Bed Entrapment Audit.

Staff interviews indicated it was the expectation in the home to complete a bed entrapment assessment for new admissions. It was also reported that if the room number was not on the bed entrapment audit then the assessment was not completed. These staff said that if a bed had failed the assessment, the maintenance staff would fix the failing zones and the bed would be reassessed to ensure it was safe. A review of the Bed Entrapment Audit with these staff revealed that beds in identified rooms had no documented record that the entrapment failed zones were fixed or if any reassessments were completed.

During an interview the Acting General Manager (AGM) acknowledged the bed assessments were not completed. AGM said that the compliance order was clear as to what needed to be done and the home did not do it and acknowledged that it

would be reissued.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be a pattern. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order. This was previously issued as a Written Notification and Compliance Order on May 16, 2016, under log #014960-16 and inspection #2016_262523_0019 with a compliance order date of May 31, 2016. [s. 15. (1)] (523)

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

Sep 30, 2016

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**Order # /**
**Ordre no :** 002

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

**Linked to Existing Order /**
**Lien vers ordre existant:** 2016_262523_0016, CO #012;

**Pursuant to / Aux termes de :**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

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

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

**Order / Ordre :**

The licensee must prepare, submit and implement a plan to ensure compliance with O. Reg. 79/10, s. 134. to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The plan must include, but not be limited to, the person responsible for and timeline to complete the following:
- a process review for monitoring and documentation of all residents' responses and the effectiveness of drugs.
- development of an audit process for the monitoring and documentation of residents' responses and the effectiveness of the drugs which includes the appointment of a management or supervisory staff person to complete the audits and regular review of the audits by the GM.
- education for all registered nursing staff of the home on the monitoring and documentation of residents' responses and the effectiveness of the drugs and particularly on the actions, plans and strategies implemented in the home as required above.

Please identify who will be responsible for completing the identified tasks and time frames when each of the components will be achieved.

Please submit the written plan to Amie Gibbs-Ward, Long-Term Care Homes Inspector - Dietary, to amie.gibbs-ward@ontario.ca by August 19, 2016.

**Grounds / Motifs :**

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

This was a follow up to an order that was previously issued on:
- May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with a compliance order date of June 30, 2016
- December 18, 2015, under log #036514-15 and inspection #2015_183128_0023 with compliance order date of January 15, 2016.

The order stated that 'The licensee shall ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs'.

A clinical record review of a medication report in the home revealed that several pain and antipsychotic medications were given as needed but medication effectiveness was not documented.

The Support Office Nurse Consultant and AGM confirmed that the staff did not document resident response for medications. The AGM reported that the report reflected that the home did not comply with the order.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be a pattern. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order. This was previously issued as a Written Notification and Compliance Order on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with a compliance order date of June 30, 2016. This was previously issued as a Written Notification and Compliance Order on December 18, 2015, under log #036514-15 and inspection #2015_183128_0023 with compliance order date of January 15, 2016. [s. 134. (a)]Order on December 18, 2015, under log #036514-15 and inspection #2015_183128_0023 with compliance order date of January 15, 2016. (523)

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

Aug 31, 2016

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

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

**Order # / Ordre no :** 003

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

**Linked to Existing Order / Lien vers ordre existant:** 2016_262523_0016, CO #011;

**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 is kept in the home for any complaint that includes 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, every date on which any response is provided to the complainant and a description of the response and any response made in turn by the complainant.

The licensee shall develop and implement an audit to ensure all documented records of verbal or written complaints in the home meet the legislation. The licensee shall appoint a management or supervisory staff person to complete the audits. This audit will be documented and reviewed on a weekly basis with the GM.

**Grounds / Motifs :**

1. The licensee has failed to ensure that a documented record was kept in the home for any complaint that included 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, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

This was a follow-up to an order that was previously issued on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with compliance date of June 30, 2016.

The order included that "The licensee shall ensure that a documented record was kept in the home for any complaint that includes 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, every date on which any response is provided to the complainant and a description of the response and any response made in turn by the complainant."

Review of the "Resident/Family Concerns Response Form" for several different verbal and written complaints made to the home showed the documented records of the complaints were incomplete.

During an interview with staff responsible for completing the forms it was reported that since the compliance order had been received by the home they had been more thorough about completing the "Resident/Family Concerns Response Form" documentation in the home. Reviewed the incomplete forms with these identified staff and it was acknowledged that the documentation was incomplete.

During an interview with the AGM it was identified that the management in the home had been working to make improvements in how verbal and written complaints were being documented. AGM reported they had recently revised the "Resident/Family Concerns" policy but the processes remained the same that specified staff were responsible for documenting the complaints and concerns in most cases and then the AGM would review once completed. Reviewed the "Resident/Family Concerns Response Form" with AGM for an identified resident and the AGM acknowledged that the documentation was incomplete and that although the home had made improvements in the process the order was not complied with.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the

non-compliance was found to be pattern. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order. This was previously issued as a Written Notification and Compliance Order on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with compliance date of June 30, 2016. This was previously issued as a Written Notification and Voluntary Plan of Correction on November 24, 2015, under log #031635-15 and inspection #2015_183128_0023. This was previously issued as a Written Notification and Voluntary Plan of Correction on September 9, 2015, under log #024284-15 and inspection #2015_217137_0040. [s. 101. (2)] (630)

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

Aug 31, 2016

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**Order # /**
**Ordre no :** 004

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

**Linked to Existing Order /**
**Lien vers ordre existant:** 2016_262523_0016, CO #016;

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

O. Reg. 79/10, s. 229 (10).

**Order / Ordre :**

The licensee will ensure the following immunization and screening measures are implemented and documented:

1. All residents who have already been admitted to the home and have not been screened for tuberculosis are screened immediately.
2. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

The licensee shall develop and implement an audit to ensure the TB screening measures are completed as required by the legislation. The licensee shall appoint a management or supervisory staff person to complete the audits. This audit will be documented and reviewed on a monthly basis with the GM.

**Grounds / Motifs :**

1. The licensee has failed to ensure the following immunization and screening

measures were in place: each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

This was a follow-up to an order that was previously issued on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with compliance date of June 30, 2016.

The order included that "The licensee will ensure the following immunization and screening measures are in place: 1. All residents who have already been admitted to the home and have not been screened for tuberculosis are screened immediately. 2. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee."

Review of the home's immunization record revealed there were five out of 190 residents who were already residents of the home, who had no record of Tuberculosis (TB) screening either through a TB skin test or chest x-ray having been completed.

Clinical record review for an identified resident showed that documentation that Tuberculosis (TB) screening either through a TB skin test or chest x-ray had not been completed within 14 days of admission. The record showed a mobile x-ray requisition had been faxed to the company but the x-ray had not been completed at the time of the inspection.

During an interview with Assistant Director of Nursing (ADON) it was identified that the home had been working to ensure the immunization record was up to date for all existing and new residents. ADON reported that they had been trying to offer TB screening to all residents but ran out of the syringes needed to complete the TB skin test and more had been ordered. ADON also reported there were delays between when a chest x-ray was requested for screening and when it was being completed by the company who provided the service to the home. Reviewed the immunization records with ADON and it was acknowledged that there were residents who had not been screened for TB in the home and therefore the order was not complied with.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be isolated. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order. This was previously issued as a Compliance Order on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with compliance date of June 30, 2016. [s. 229. (10) 1.] (630)

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

Sep 30, 2016

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**Order # /**
**Ordre no :** 005

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

**Linked to Existing Order /**
**Lien vers ordre existant:** 2016_262523_0016, CO #007;

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 9. Doors in a home

**Order / Ordre :**

The licensee shall ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, and shall educate all staff on this policy.

**Grounds / Motifs :**

1. The licensee has failed to ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

This was a follow up to an order that was previously issued on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with a compliance order date of June 30, 2016.

The order included that 'The licensee shall ensure that all doors leading to non-residential areas are kept locked when they are not being supervised by staff. The licensee shall ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, and shall educate all staff on this policy'.

Observations during this inspection revealed that all doors leading to non-residential areas were kept locked.

An interview with AGM revealed that the Building Safety and Security Policy was updated in May 2016.

A review of the policy with AGM revealed that the policy did not deal with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

A review of the compliance order with the AGM found the policy did not include direction to staff as to when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. AGM said in an interview that the order was not complied with.

During the inspection this non-compliance was found to have the severity level of a minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was found to be isolated. The home has had ongoing non-compliance with this section of the legislation including previous issuance of an order. This was was previously issued as a Compliance Order on May 12, 2016, under log #007195-16 and inspection #2016_262523_0016 with a compliance order date of June 30, 2016.(523) [s. 9.] (630)

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :**

Sep 30, 2016(A1)

## 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

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

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

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
Toronto ON  M5S 2B1
Télécopieur : 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 5 day of August 2016 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** AMIE GIBBS-WARD - (A1)

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