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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 19, 2016	2016_293554_0001	001013-16	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

BALLYCLIFFE LODGE NURSING HOME
70 STATION STREET AJAX ON L1S 1R9

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

KELLY BURNS (554), CAROLINE TOMPKINS (166), DENISE BROWN (626), KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 25-29, 2016, and February 01-04, 2016

During this Resident Quality Inspection (#001013-16), the following intakes were

reviewed and inspected upon concurrently #003751-15, 007100-15, 007503-15, 011427-15, 022358-15, 025703-15, 027614-15, 029844-15, 030743-15 and 001216-16.

Summary of the Intakes:
1) #003751-15 - Complaint, regarding a resident being discharged from the home. Relating to the same resident, two Critical Incident Reports were inspected upon, specific to a missing resident and resident exhibiting responsive behaviours.
2) #007100-15 - Complaint, regarding the overall condition of the home and maintenance within the home lacking.
3) #007503-15 - Complaint and Critical Incident Report, allegation of abuse, which included concerns specific to falls, staffing and slow response of staff to call bells.
4) #011427-15 - Follow Up to a Compliance Order (and Directors Referral), specific to O. Reg. 79/10, s. 19 (4)- Generator Access.
5) #022358-15 - Critical Incident Report, regarding a missing resident, during a scheduled activity outing.
6) #025703-15 - Critical Incident Report, regarding flooding in the home; one resident evacuated to the attached Retirement Home.
7) #027614-15 - Critical Incident Report, regarding staff to resident abuse.
8) #029844-15 - Complaint, regarding lack of maintenance repairs in the home, garden patio and courtyard in disrepair and generator issues.
9) #030743-15 - Complaint, regarding alleged staff to resident abuse; as well, as staffing and care issues.
10) #001216-16 - Critical Incident Report, regarding alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Director of Care (DOC), Office Manager, Receptionist, Program Manager, Acting Dietary Manager, Environmental Services Manager (ESM), Registered Dietitian (RD), RAI-Coordinator, Corporate Representatives, Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), Housekeeping Aide(HSK Aide), Dietary Aide(DA), Residents and Families.

During the course of this inspection, the inspector(s)toured the home, reviewed clinical health records, observed staff to resident interactions, reviewed resident and family council meeting minutes, reviewed home investigational notes (specific to identified Critical Incident Reports), reviewed maintenance requisition log binder, installation records specific to a transfer switch and associated ESA certification, reviewed home specific policies related to Resident Abuse-Abuse Prevention, Resident Falls, Responsive Behaviours, Skin Care Program,

Complaints, Maintenance Work Order and Log Book, Housekeeping Protocols, Deep Cleaning and Emergency Response Plan (specific to loss of power).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **4 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. 19. (4)	CO #001	2015_178102_0026	554

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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (a), by not ensuring that the home, furnishings and equipment are kept clean and sanitary.

The following observations were made during the dates of this inspection:

- the shower stall, located on the second floor, was observed to have a blackish, moist substance in all of the four corners of the shower stall, along the ceramic tile, and inside edges of the shower stall. It was further observed that the ceramic wall tiles and the flooring inside the shower stall had a dark yellowish-brown residue on and between the tiles;

- the ceramic flooring located on the adjacent sides of the shower stall were observed to be covered with a whitish residue, as well as a blackish substance was observed along the corner edges of the flooring, in this same area (second floor shower room);

- dark yellowish-brown staining was visible around the base of the toilet and surrounding flooring in ten resident washrooms;

- flooring in both resident rooms and adjoining washrooms were observed to have a build-up of blackish substance between flooring tiles in fifteen resident rooms and adjoining washrooms; this debris could be easily scraped with the inspectors pen.

Environmental Services Manager (ESM) indicated (to the inspector) the following:
- The shower stall and flooring, located on the second floor, needed a "good scrubbing" by housekeeping staff. ESM indicated there was no reason for the shower or flooring to be unclean;

- There should be no stains at the base of the toilets and along surrounding flooring. A additional housekeeping staff is assigned monthly to scrub around the base of the toilets and surrounding flooring, but the majority of the staining and or soiling should be cleaned with the day to day cleaning of resident washrooms;
- The housekeepers and or maintenance staff are unable to properly clean resident rooms and adjoining washrooms flooring as the Orbitor, the electronic floor scrubber, scrubs too hard at the floors and causes the floor tiles to separate further, which poses additional flooring concerns (as noted under LTCHA, s. 15 (2)(c)).

Environmental Services Manager indicated it is an expectation that the home be kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the dates of this inspection:

- Walls – damage was visible (holes in the wall plaster, or exposed corner steel beading) in specific resident rooms and adjoining washrooms; in the resident washroom located in computer room (third floor) and in the second floor tub room; areas of "buckling or bubbling" were noted on hallway walls on the second and third floor, as well as the lounge on the first floor (resident home area);

- Wall Guards – loose, lifting or missing in specific resident rooms and adjoining washrooms; as well as in the hallway on the second floor;

- Flooring – laminate floor tiles chipped and or cracked in specific resident rooms and adjoining washrooms; in the washroom adjacent to the computer room; first and second floor tub rooms, and in areas throughout the hallways on the first, second and third floor resident hallways;

- Flooring – laminate tiles in specific resident rooms and adjoining washrooms – were observed to be separating; space between flooring tiles had build-up of blackish debris (substance) visible;

- Flooring – laminate floor tiles observed to have rusted areas, on the flooring under counter-top vanity/sink area, in identified resident washrooms;

- Toileting Rails - attached to both side of the toilet were observed to be loose and wobbly in one resident washroom; resident residing in the room indicated the toileting rails have been like that since he/she moved in;

- Ceiling Tiles – yellowish-brown staining visible on ceiling tiles located in identified resident washrooms; (note: two of these rooms, were noted as needing replacement during an October 2015 Maintenance Audit, by ESM)

- Tub Room – the ceramic wall tile in the tub room, located on the first floor, was observed to be chipped and having missing wall tiles; the wall edge was observed to be jagged;

- Counter-Top Vanity – chipped, gouged or having areas of the laminate surrounding the counter missing in identified resident washrooms, and along the sink-counter top in the dining room;

- Sink-Vanity Frame – observed to be chipped with missing paint (metal exposed) in two resident washrooms;

- Doors and Door Frames – chipped, gouged or paint missing in specific resident room and adjoining washrooms; as well as the first and second floor tub and shower rooms; it was also observed that the plastic door guard in three resident rooms were lifting or gouged along door way edges (these areas were jagged);

- Wardrobe (closets) – the latching mechanism or door closure on home owned wardrobes were non-existent or malfunctioning in specific resident rooms; wardrobes were observed damaged (laminate gouged, chipped or missing in areas) in six resident rooms;

- Carpet – transition or threshold (entry to lounge/computer room on the third floor) was observed to be frayed and lifting;

- Door Drafts – cold air could be felt, entering the home from the outside as inspector stood beside doors in the family room and computer room; there was a space (approximately half an inch) visible between the bottom of the door (in the family room) and the transition piece;

- Chairs – home owned wooden chairs in the dining room, family room, activity (auditorium) room and in the computer room (third floor) were observed to have paint chipped (and or missing) on the arms, back and legs of the chairs;

- Sara Lifts (resident transfer device) – two Sara 3000 lifts (located on the first floor, resident home area) were observed to have paint chipped and or areas of rust along the lower frame (legs of the lift)

Personal Support Workers, Registered Nursing Staff, as well as the Environmental Services Manager indicated that any needed repairs or maintenance issues are to be placed into the maintenance binders located at the nursing stations for follow up by maintenance.

A review of the maintenance binder for the period of one month, failed to provide documentation that repairs noted above by the inspector(s) were identified by maintenance workers (or the department) as needing repairs and or replacement.

Environmental Services Manager (ESM) and Administrator indicated the following:
-Day to day maintenance issues (damage to walls, wall guards, doors, ect) were prioritized based on safety issues. ESM indicated that maintenance repairs are completed as the individual resident room is painted. ESM indicated that room painting is completed as per the painting schedule, which is two resident rooms per month.
- Flooring – damaged (chipped or broken tiles) or separating tiles within the home had been identified and addressed with Corporate Office. ESM indicated that Corporate Office hired an environmental consultant to look at the flooring issues. The environmental consult concluded that areas of the flooring contained asbestos. As of time of this inspection both the Administrator and ESM indicated the flooring cannot be fixed due to the asbestos and that no plans were in place to deal with the asbestos issues.
- Counter-Top Vanities – was aware that some counter-top vanities needed to be replaced, but at this time, there were no plans in place to repair or replace the vanities.

Environmental Services Manager indicated being aware of some of the repairs identified above, but indicated he and the maintenance department rely on staff to communicate repairs.

2. Related to Intake #025703-15:

Resident #017 indicated that he/she was relocated to a room in the attached retirement

home, on a specific date due to his/her room being flooded. Resident indicated he/she was relocated for approximately one week while water damage was repaired to walls and flooring in her room. Resident #017 indicated the flooding on the identified date, was not the first flood to have occurred in the room. Resident #017 indicated, that he/she was told, that the flood in the room had occurred due to issues with malfunctioning of the downspouts coming from the roof-top.

Resident #017 indicated that since the incident, the home has relocated the downspouts away from his/her room.

The Environmental Services Manager indicated that the flooding of resident's room (and a second floor resident room) was caused by an eaves trough and down spout being clogged and not functioning properly. Environmental Services Manager indicated that the non-functioning eaves trough and down spout has been since condemned and a new down spout has been established.

During this inspection, an aluminium down spout (a portion of the down spout, approximately nine foot length), located at the front of the home, was observed to be crushed. The aluminium elbow, connected to the crushed down spout, was dripping with water and a puddle of water was observed underneath the elbow.

Family #050 indicated that aluminium down spout located at the front of the home has been damaged (crushed) for approximately one year. Family #050 indicated that water puddles (or ice) accumulate under the elbow of the down spout and at the corner of the home, parking lot and resident smoking area on a regular basis. Family #050 indicated that the water accumulation is due to damaged down spouts and intern poses a potential safety hazard.

3. Related to Intake #029844-15:

Family #048 indicated that the garden patio and courtyard has been in a state of disrepair (cracked and or broken concrete and uneven interlocking bricks) for approximately one year. Family #048 indicated that the garden patio and courtyard disrepair make it difficult for residents and families to use the areas, as such poses a safety (trip and fall) hazard. Family #048 indicated bringing this concern forward to the Administrator and also the now Acting Administrator without resolution to the disrepair. Family #048 indicated that the Family Council has also voiced concerns, specific to the garden patio and courtyard on more than one occasion.

A review of the Family Council Meeting Minutes provides documentation that members of Family Council raised concerns, specific to the disrepair in the courtyard and garden patio, to the Administrator and or Acting Administrator during meetings held January, September and November of 2015.

A letter, on a identified date, was forwarded to the Administrator, by the Family Council, asking about the patio and courtyard repairs; a written response from the Administrator, seven days later, indicated that a contractor would be brought into the home in Spring of 2015 to assess the patio /courtyard issues and provide the home with possible solutions.

During this inspection, sections of the front entrance walkway, resident smoking area, and the courtyard/garden patio were observed to have cracked, chipped and uneven concrete, as well as uneven interlocking patio stones. A portion of the courtyard walk-way was roped off with yellow caution tape.

The Environmental Services Manager indicated that portions of the courtyard were roped off with caution tape, as the tree roots, in this area, were emerging from the earth and causing the walk-way to be uneven. Environmental Services Manager indicated that residents and families were unable to use the roped off section due to safety reasons.

The Acting Administrator indicated that there are currently no plans in place for repair of the garden patio and or courtyard.

4. Related to Intake #007100-15:

Family #050 indicated that his/her family (resident #051) moved into the home approximately a year ago. Family #050 indicated that an electrical outlet/receptacle behind resident #051's bed was damaged, rendering it unusable, since the time of resident #051's admission to the home. Family #050 commented that the electrical outlet/receptacle had not been fixed until the afternoon of January 25, 2016. Family #051 indicated bringing this concern forward on more than one occasion to nursing staff and the Acting Administrator without resolution.

Environmental Services Manager indicated being aware of the damaged electrical outlet; ESM indicted the outlet/receptacle was identified as an issue during a maintenance audit which was conducted November 2015. ESM could not recall why the damaged outlet/receptacle was not fixed.

Environmental Services Manager acknowledged that the electrical outlet/receptacle was not fixed until January 25, 2016.

Administrator and Environmental Services Manager indicated that it would be an expectation the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, but indicated that repairs needed are costly and the hope is to rebuild the home. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 there is a monitoring process in place to ensure that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care set out for resident #041 had clear directions to staff and others who provide direct care to the resident.

Resident #041 has a cognitive impairment and has been identified as high risk for falls. Resident #041 has been found on the floor next to bed on seven occasions since admission.

Review of resident #041's care plan in place indicated that a floor mat and bed alarm intervention was created for resident #041 on a specific date. The care plan interventions did not identify where the floor mat was to be placed and did not identify that the alarm was used while in the wheelchair.

Review of resident #041's progress notes identified that on an identified date, and time, the resident was found on the floor next to bed with no injury. RN#126 documented in resident #041's progress notes that resident #041 did not have the floor mat and bed alarm in place at the time of the fall.

Review of resident #041's progress notes identified that later the same day the resident was found on the floor next to the bed holding onto side rail by the window, with no injury. Review of the Post Fall Analysis completed by RPN #121 indicated the assistive devices that were in place at the time of the fall included a high low bed; the bed was in the lowest level and unlocked. There was no documentation indicating that the floor mat and bed alarm were in place at the time of the second fall.

During an interview, PSW#127 indicated providing care for resident #041 on a specific date and that resident #041 did not have a bed alarm in place. PSW #127 indicated not being aware of resident #041 having an intervention to apply bed alarm or wheelchair alarm.

During an interview, PSW#128, RPN#110, RPN#118 indicated that resident #041 had been identified as a fall risk and the alarm was required in bed and while sitting in the wheelchair. The floor mat is placed on the side of the bed that the resident gets out of bed and the bed is to be in the lowest position.

Observation of resident #041 while sitting up in the wheelchair on February 02, 2016, by RPN #110 and Inspector #601 identified that resident #041 did not have a wheelchair alarm in place. Resident #041's room was observed by RPN #041 and an inspector and a bed alarm was not located in the resident's room.

Therefore, the plan of care set out for resident #041 did not provide clear directions to staff and others who provide direct care to the resident. On an identified date resident #041 was found on the floor on two occasions, the floor mat and bed alarm were not in place as identified in the care plan. During an interview, PSW #128, RPN #110, RPN #118 indicated that resident #041 required an alarm while in bed and while sitting in the wheelchair. PSW #127 indicated not applying resident #041's alarm while sitting in wheelchair on February 02, 2016 and also indicated not being aware that resident #041 required an alarm while in bed and while sitting in the wheelchair. [s. 6. (1) (c)]

2. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care is provided to resident #018 as specified in the plan, specific to continence care, and toileting of a resident.

Resident #018 is dependent on nursing staff for transferring and toileting. Resident #018 is cognitively well.

The plan of care for resident #018, directs the following:

- Toileting – resident requires assistance with toileting; goals of care indicate, resident will be toileted as per resident's needs. Interventions include, resident will let the staff know when he/she needs to use the washroom.
- Transfers – resident requires assistance with transfers; interventions include, staff to assist with all transfers.

Resident #018 approached the inspector and indicated the following:

- Resident asked to use the toilet and was told by PSW #119 just do it in the bed. Resident #018 indicated that another worker was in the room at the time of the incident and over heard what PSW #119 had said. Resident #018 indicated that the incident occurred yesterday.

Resident #018 indicated that he/she is normally continent; resident indicated that the remarks made by PSW #119 made him/her feel low and degraded. Resident #018 indicated that this was not the first time PSW #119 had refused to toilet him/her; resident further indicated other PSWs have also refused to toilet him/her on occasions.

PSW #120 indicated being in resident #018's room at the time of the incident, and had heard what PSW #119 had said to Resident #018. PSW #120 confirmed the incident took place the day prior to resident's report to the inspector.

The incident, in which resident #018 was refused toileting by PSW #119 was reported by the inspector to the Director of Care, on February 02, 2016; day in which resident #018 reported the incident.

The Director of Care indicated that the incident was unacceptable. Director of Care indicated it is an expectation that residents are to be provided care (e.g. toileting) as per their individual plan of care or when a resident requests such. [s. 6. (7)]

3. The licensee has failed to ensure that different approaches have been considered in the revision of resident #042's plan of care when care set out in the plan has not been effective.

Related to Intake #007503-15:

Review of clinical documentation related to falls indicated that resident #042 has experienced thirty three falls over a period of approximately one year. Falls have occurred at all times of the day, evening and during the night. To this date, the resident has not sustained any injury related to falls.

Resident #042's plan of care related to falls directs staff to:
FALLS:Resident has been identified as a high risk for falls. Goal of care, resident will not fall or sustain injury. Interventions listed include, clip call bell within resident's reach when resident is in room; ensure appropriate safety device is in use - hip protector; resident will often refuse to wear; staff to encourage the resident to wear hip protector daily. High-low bed; sensor-bed/chair alarm system is in use; floor mat on floor at bedside; ensure that anti-slip mat is in use on the wheelchair cushion daily to prevent resident from sliding out of chair; leave bathroom light on at night; monitor resident's where about frequently; remind resident to call for assistance and wait before getting up; staff will place all necessary items within reach to avoid excessive reaching; staff will redirect resident to wheelchair if the resident is found walking unsafely.

Review of resident #042's plan care related to falls, over a period of one year (specific months reviewed), indicated the interventions in place to prevent or mitigate resident #042's falls have not been effective and no other approaches were considered when the resident continued to have falls inspite of the interventions in place. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a monitoring process in place to ensure, the plan of care set out for residents has clear directions to staff and others who provide direct care to the resident; ensuring the care set out in the plan of care is provided to the resident as specified in the plan, specific to continence care, and toileting of a resident; and to ensure that different approaches have been considered in the revision of residents plan of care when care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 23 (1) (a), by not ensuring that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, specifically as it relates to abuse by anyone or neglect of a resident by the licensee or staff.

Under O. Reg. 79/10, s. 5, for the purpose of the Act and this Regulation, the definition of neglect, is defined the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction, or a pattern of in action that jeopardizes the health, safety or well-being of one of more residents.

Related to Resident #001:

Resident #001 reported, to an inspector, that he/she had asked to use the washroom and was told by staff, we don't have time for that; just do it in the bed. Resident #001, also reported, being bathed in cold water. Resident indicated being upset with how he/she was being treated.

The incidents described by resident #001 were reported, by the inspector, to the Administrator on January 27, 2016.

On February 01, 2016, the Administrator was asked, by the inspector, where the home was at with the investigation of resident #001's concerns, Administrator indicated, it's being looked into.

On February 02, 2016, the Director of Care was asked, by the inspector, for a copy of the home's investigation into resident #001's concerns. Director of Care indicated initially having no knowing of resident #001's concerns. During a second interview, Director of Care indicated, having been told of the concerns of resident #001 by the Administrator on January 27, 2016, and commented she had not had time to investigate concerns.

The Director of Care indicated that not toileting a resident would be considered neglect of care, and that an allegation of neglect was to be immediately investigated as per the home's policy, Resident Abuse-Abuse Prevention.

The concerns voiced by resident #001 were not immediately investigated by the licensee. The investigation was not initiated for a period of eight days following the initial report to the Administrator. [s. 23. (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 there is a monitoring process in place to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, specifically as it relates to abuse by anyone or neglect of a resident by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 221 (2), by not ensuring that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention, as determined by the license, based on the assessed training needs of the individual staff.

Under LTCHA, 2007, s. 76 (4), every licensee shall ensure that the persons who have received training under subsection (2) receives training in the areas mentioned in that subsection, at times or intervals provided for in the regulation, specifically, Resident's Bill of Rights, and the home's policy to promote zero tolerance of abuse and neglect of resident.

Under LTCHA, 2007, s. 76 (7), every licensee shall ensure that all staff who provide direct care to residents receive as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or intervals provided for in the regulations, specifically, abuse recognition and prevention; and behaviour management.

The Director of Care submitted a Critical Incident Report to the Director, on a identified date, specific to staff to resident abuse.

Details of this incident are as follows:
- PSW #112 was heard by two PSWs (#113, and #114) yelling at resident #054 during a bath. PSW was heard yelling, what the hell do you think you are doing.

The Director of Care indicated that PSW #112 had been involved directly with other incidents involving staff to resident abuse; one of the incidents was just six days earlier and another approximately a month earlier. The Director of Care indicated that her plan, following the three incidents was to provide re-training to PSW #112, specific to zero tolerance of abuse and communication with residents with cognitive impairments.

Director of Care indicated that, the re-training of PSW #112 had not yet taken place, as she (the DOC) had not had the opportunity to complete PSW's retraining. [s. 221. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a monitoring process in place to ensure that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention, as determined by the license, based on the assessed training needs of the individual staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 14, by not ensuring each resident shower have at least two easily accessible grab bars, one grab bar located on the same wall as the faucet and one grab bar located on the adjacent wall.

The following was observed:

- The shower, located in the shower room on the second floor (resident home area), did not have a shower grab bar located on the same wall as the faucet.

Personal Support Workers (interviewed by inspector) indicated the shower is being used to provide showers to residents residing on both the second and third resident home areas.

Environmental Services Manager (ESM) was not aware that the shower was required to have a shower grab bar on the same wall as the faucet. [s. 14.]

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

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 20 (1), by ensuring that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The home's policy, Resident Abuse-Abuse Prevention (#LTC-CA-ALL-100-05-02), directs that abuse reporting is mandatory. All staff members are required to report any abuse (allegations, suspected or witnessed) immediately to their respective supervisors. The home's policy describes a supervisor as the Administrator, Director of Care, designated manager and or the registered nursing staff. The policy directs that all provincial legislative requirements will be followed in incidences of alleged, suspected or witnessed abuse. All reports of abuse are to be investigated immediately by the supervisor who receives the report. The investigation includes, immediate notification and mandatory reporting to the governing provincial authority (e.g. MOHLTC). Reports are to be forwarded to the provincial authority using the method (phone, written report) directed by the province.

Resident Abuse-Abuse Prevention (#LTC-CA-ALL-100-05-02) policy outlines that all events related to a reported allegation (of abuse) are to be documented in the resident health record. The policy, further stipulates the requirement for the completion of the Resident Incident Report form.

Related to Intake #027614-15:

Resident #056 witnessed PSW #123 and a PSW #125 providing care to resident #055, on an identified date. Resident #056 indicated, PSW #125 tapped on resident #055's body with his/her hands, and the PSWs were also laughing. Resident #056 indicated

having witnessed the incident of physical abuse, and reported the abuse incident to a PSW; the PSW then reported the allegation of abuse to RN #124. The incident was reported to RN #124 on the same shift as it was witnessed.

During an interview, the DOC indicated uncertainty that the alleged staff to resident physical abuse was documented and or an incident report completed.

During an interview, RN #124 confirmed that the alleged staff to resident physical abuse of resident #055, which was reported by resident #056 was not documented nor was an incident report completed.

In an interview, PSW #125 affirmed that an incident report was not completed pertaining to the alleged staff to resident physical abuse involving resident #055.

A review of residents #055 and #056 health records, for a three day period, found no documentation of the alleged staff to resident physical abuse in the progress notes, occurrence/incident notes and risk management under the title of abuse. [s. 20. (1)]

2. Related to Resident #018:

Resident #018 approached an inspector and indicated the following:

- Resident #018 asked to use the washroom and was told by PSW #119, just do it in the bed. Resident #018 indicated that another worker was in the room at the time of the incident and had heard what PSW #119 had said. Resident #018 indicated that the incident occurred yesterday. Resident #018 indicated that this was not the first time, he/she had been refused toileting by PSW #119 and or other PSWs.

PSW #120 indicated being present in resident #018's room at the time of the incident, and had witnessed the incident between resident #018 and PSW #119. PSW #120 indicated that the incident took place one day earlier.

PSW #120 indicated that refusal to toilet a resident would be considered abuse/neglect of care. PSW #120 indicated that he/she had not reported the incident to the Charge Nurse, the Director of Care or any other staff working at the long-term care home, as he/she was fearful of retribution by PSW #119. PSW indicated having had training on the home's zero tolerance of abuse policy when he/she began placement at the long-term care home.

Director of Care confirmed that PSW #120 did have training, specific to zero tolerance of abuse and mandatory reporting, during orientation. Director of Care indicated that PSW #120 should have immediately reported the incident to either the Charge Nurse on the resident home area or to the DOC.

3. Related to Resident #029:

Resident #029 approached both RPN #121 and RN-Supervisor #122, on an identified date, and indicated to the registered nursing staff being upset as to how he/she was spoken to and treated during a bath, by PSW #112; resident indicated that the treatment by PSW #112 caused discomfort. RN #122 indicated reporting resident #029's concern to DOC on the same day, as reported by the resident.

The allegation of physical abuse of resident #029, by PSW #112, was reported by RN #122 to the Director of Care, both verbally and in writing.

Director of Care acknowledged receipt of the letter from RN-Supervisor #122 and indicated receiving it the same day as it was written. The Director of Care acknowledged, that incident which occurred and resident reporting discomfort would be seen as abuse.

The allegation of physical abuse (staff to resident), which occurred on a specific date, was not immediately reported to the Director by Registered Nurse-Supervisor #122 or the Director of Care. As of the date of this inspection, the licensee has failed to provide a report to the Director regarding incident.

The Director of Care indicated that all staff are expected to follow the home's policies. [s. 20. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 24 (1) 2, by not ensuring the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" is defined as (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Related to Resident #029:

Resident #029 approached both RPN #121 and RN-Supervisor #122, on an identified date, and indicated to the registered nursing staff being upset as to how he/she was spoken to and treated during a bath, by PSW #112. Resident further indicated that the treatment by PSW #112 caused him/her discomfort.

The allegation of physical abuse of resident #029, by PSW #112, was reported by RN #122 to the Director of Care, on the same date to which the incident occurred; the report was submitted both, verbally and in writing.

The Director of Care indicated that resident #029 did not directly report the abuse incident to her, during their meeting, and therefore she could not determine if abuse had occurred or not. Director of Care acknowledged receipt of the letter from RN-Supervisor #122 and indicated receiving it the same day as it was written.

The Director of Care acknowledged, that incident and discomfort reported by Resident #029, would be seen as abuse.

The allegation of physical abuse (staff to resident), which occurred on an identified date, was not immediately reported to the Director by the Director of Care. [s. 24. (1)]

2. Related to Intake #027614-15:

On an identified date, resident #056 reported an alleged staff to resident physical abuse involving resident #055, by PSW's #123 and #125.

During an interview, the DOC confirmed that resident #056 reported the alleged physical abuse to PSW #125 on the date when the incident occurred.

The charge nurse RN #124 affirmed that PSW #123 immediately reported the alleged staff to resident physical abuse to RN #124.

During an interview, RN #124 indicated that the incident was not documented and was not reported to the Director of Care or the Administrator.

The DOC confirmed that resident #056's family member left a telephone message regarding the alleged staff to resident physical abuse. The DOC indicated that the Director was informed upon being told of the alleged physical abuse by the resident #056's family member, which was two days following the initial incident.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 76 (4), by not ensuring that all staff have received retraining annually relating to the following:

• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24
• The whistle-blowing protections

The Administrator indicated that only 96% of staff have been provided annual retraining for 2015, specific to the above indicated requirements.

Administrator indicated that staff not retrained, were for the most part casual staff, or staff who were on leaves of absence during some months in 2015. Administrator indicated, staff not retrained had worked during some point in 2015, and should have completed their annual retraining. [s. 76. (4)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

Licensee failed to comply with the LTCHA, 2007 s. 85 (1) (3) in seeking the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview, with the Family Council President (#048) indicated that he/she has not seen a satisfaction survey and does not recall the involvement of the council.

During an interview, the DOC confirmed that she does not believe that the Family Council had a chance to provide input about the Resident Satisfaction Survey as it done Corporately.

The Administrator confirmed that the advice of Family Council was not solicited in the development and carrying out of the Resident Satisfaction Survey.

2. Licensee failed to comply with the LTCHA, 2007 s. 85. (4) (a) in documenting and making available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

During an interview, the Family Council President (Family #048) indicated that the Family Council has not received the results of the Resident Satisfaction Survey and that it is posted in the home.

During an interview, the DOC indicated that the Resident Satisfaction Survey results were available to the home in October, 2015.

The Administrator confirmed that the results of the Resident Satisfaction Survey were not shared with the Family Council, since its availability to the home in October 2015.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to comply with O. Reg. 79/10, s. 87 (2) (d), by not ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours.

The following observations were made during dates of this inspection:

Three resident rooms and adjoining washrooms were noted during this inspection, on more than one date and at specific times, to have a strong and lingering malodour; the smell resembled a urine-like odour. The odour was strongly smelt as the inspector entered the shared washrooms. The washrooms in two of the identified resident washrooms, were observed to have dark brownish staining at the base of the toilet and along the surrounding flooring.

Environmental Services Manager was not aware of the lingering and offensive odours in the identified resident rooms and or washrooms.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

The licensee has failed to comply with O. Reg. 79/10, s. 97 (1) (a), by not ensuring the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that, resulted in a physical injury or pain to the resident; or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Related to Resident #029:

Resident #029 approached both RPN #121 and RN-Supervisor #122, on an identified date, and indicated to the registered nursing staff being upset as to how he/she was spoken to and treated during a bath, by PSW #112. Resident #029 indicated that the treatment by PSW #112 caused him/her discomfort. RN #122 indicated reporting resident #029's concern to DOC on the same day as reported by the resident.

Registered Nursing Staff, as well as the Director of Care, indicated that substitute decision maker (SDM) of Resident #029 had not been immediately contacted as to the incident which occurred on a specific date.
As of this inspection, the incident had not been reported to the family of resident #029.

2. The licensee has failed to comply with O. Reg. 79/10, s. 97 (1) (b), by not ensuring that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed

incident of abuse or neglect of the resident.

Related to Intake #027614-15:

On an identified date, resident #056 reported an allegation staff to resident physical abuse involving resident #055, by PSW's #123 and #125.

During an interview, the DOC confirmed that resident #056 reported the allegation of physical abuse to PSW #125 on the date when the incident occurred.

The charge nurse RN #124 affirmed that PSW #123 and #125 immediately reported the allegation of staff to resident physical abuse to him/her.

During an interview, RN #124 indicted that resident #055's substitute decision maker was not informed of the alleged staff to resident physical abuse to date.

The DOC also acknowledged that Resident #055's substitute decision maker was not informed of the alleged physical abuse.

3. Related to Resident #001:

During this inspection, resident #001 reported that he/she had asked to use the washroom and was told by staff, we don't have time for that; just do it in the bed. Resident #001, also reported, being bathed in cold water. Resident #001 indicated that he/she was refused toileting on more than one occasion by the same staff. Resident indicated being upset with how he/she was being treated.

The incidents described by Resident #001 were reported, by the inspector, to the Administrator on the same date reported by the resident.

The Director of Care indicated, to the inspector, that the substitute decision maker for Resident #001 has not been notified of the concern voiced by the Resident #001 until seven days later, as he/she had forgotten to look into the alleged incidents.

Issued on this 24th day of February, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére 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

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) :	KELLY BURNS (554), CAROLINE TOMPKINS (166), DENISE BROWN (626), KARYN WOOD (601)
Inspection No. / No de l'inspection :	2016_293554_0001
Log No. / Registre no:	001013-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 19, 2016
Licensee / Titulaire de permis :	Chartwell Master Care LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	BALLYCLIFFE LODGE NURSING HOME 70 STATION STREET, AJAX, ON, L1S-1R9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marie Gagnon

To Chartwell Master Care LP, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary;

(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee will prepare, implement and submit a corrective action plan to ensure that the home, furnishings and equipment are maintained in safe condition and in a good state of repair including:

- repair, refinish and/or replace, as appropriate, all damaged floor surfaces in resident rooms, hallways, common areas and tub/shower rooms;
- repair and/or replace, as appropriate, all damaged doors and door frames, which includes two doors leading to the outside (family room and computer room) where a cold air draft was identified;
- repair and/or replace, as appropriate, all damaged walls in resident rooms, lounges, hallways and tub/shower rooms;
- repair and/or replace, as appropriate, all damage ceiling tiles,
- repair and/or replace, as appropriate, all damaged wardrobes (closets);
- repair and/or replace, as appropriate, all damaged counter-top vanities;
- repair and/or replace, as appropriate, all damaged toileting rails (hand rails);
- repair and/or replace, as appropriate, all damaged home owned wooden chairs, specifically in the dining room, family room, and activity room;
- repair and/or replace, as appropriate, all damaged down spouts (and or eaves troughs);
- repair and/or replace, as appropriate, all damaged concrete walk-ways and patios, as well as the damaged or lifting inter-locking patio stones located in the garden and or courtyard.

The licensee will develop and implement a process that clearly identifies areas of disrepair in the home. The process must also include who will be responsible for completing the repairs and the date the repairs are to be completed.

The licensee will provide a written plan on or before March 04, 2016. The plan must be submitted in writing and forwarded to the Attention of: LTC Homes Inspector (Nursing) - Kelly Burns, via fax, at (613) 569-9670.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the dates of this inspection:

- Walls – damage was visible (holes in the wall plaster, or exposed corner steel

beading) in specific resident rooms and adjoining washrooms; in the resident washroom located in computer room (third floor) and in the second floor tub room; areas of "buckling or bubbling" were noted on hallway walls on the second and third floor, as well as the lounge on the first floor (resident home area);

- Wall Guards – loose, lifting or missing in specific resident rooms and adjoining washrooms; as well as in the hallway on the second floor;

- Flooring – laminate floor tiles chipped and or cracked in specific resident rooms and adjoining washrooms; in the washroom adjacent to the computer room; first and second floor tub rooms, and in areas throughout the hallways on the first, second and third floor resident hallways;

- Flooring – laminate tiles in specific resident rooms and adjoining washrooms – were observed to be separating; space between flooring tiles had build-up of blackish debris (substance) visible;

- Flooring – laminate floor tiles observed to have rusted areas, on the flooring under counter-top vanity/sink area, in identified resident washrooms;

- Toileting Rails - attached to both side of the toilet were observed to be loose and wobbly in one resident washroom; resident residing in the room indicated the toileting rails have been like that since he/she moved in;

- Ceiling Tiles – yellowish-brown staining visible on ceiling tiles located in identified resident washrooms; (note: two of these rooms, were noted as needing replacement during an October 2015 Maintenance Audit, by ESM)

- Tub Room – the ceramic wall tile in the tub room, located on the first floor, was observed to be chipped and having missing wall tiles; the wall edge was observed to be jagged;

- Counter-Top Vanity – chipped, gouged or having areas of the laminate surrounding the counter missing in identified resident washrooms, and along the sink-counter top in the dining room;

- Sink-Vanity Frame – observed to be chipped with missing paint (metal exposed) in two resident washrooms;

- Doors and Door Frames – chipped, gouged or paint missing in specific resident room and adjoining washrooms; as well as the first and second floor tub and shower rooms; it was also observed that the plastic door guard in three resident rooms were lifting or gouged along door way edges (these areas were jagged);

- Wardrobe (closets) – the latching mechanism or door closure on home owned wardrobes were non-existent or malfunctioning in specific resident rooms; wardrobes were observed damaged (laminate gouged, chipped or missing in areas) in six resident rooms;

- Carpet – transition or threshold (entry to lounge/computer room on the third floor) was observed to be frayed and lifting;

- Door Drafts – cold air could be felt, entering the home from the outside as inspector stood beside doors in the family room and computer room; there was a space (approximately half an inch) visible between the bottom of the door (in the family room) and the transition piece;

- Chairs – home owned wooden chairs in the dining room, family room, activity (auditorium) room and in the computer room (third floor) were observed to have paint chipped (and or missing) on the arms, back and legs of the chairs;

- Sara Lifts (resident transfer device) – two Sara 3000 lifts (located on the first floor, resident home area) were observed to have paint chipped and or areas of rust along the lower frame (legs of the lift)

Personal Support Workers, Registered Nursing Staff, as well as the Environmental Services Manager indicated that any needed repairs or maintenance issues are to be placed into the maintenance binders located at the nursing stations for follow up by maintenance.

A review of the maintenance binder for the period of one month, failed to provide documentation that repairs noted above by the inspector(s) were identified by maintenance workers (or the department) as needing repairs and or replacement.

Environmental Services Manager (ESM) and Administrator indicated the following:
-Day to day maintenance issues (damage to walls, wall guards, doors, ect) were

prioritized based on safety issues. ESM indicated that maintenance repairs are completed as the individual resident room is painted. ESM indicated that room painting is completed as per the painting schedule, which is two resident rooms per month.
- Flooring – damaged (chipped or broken tiles) or separating tiles within the home had been identified and addressed with Corporate Office. ESM indicated that Corporate Office hired an environmental consultant to look at the flooring issues. The environmental consult concluded that areas of the flooring contained asbestos. As of time of this inspection both the Administrator and ESM indicated the flooring cannot be fixed due to the asbestos and that no plans were in place to deal with the asbestos issues.
- Counter-Top Vanities – was aware that some counter-top vanities needed to be replaced, but at this time, there were no plans in place to repair or replace the vanities.

Environmental Services Manager indicated being aware of some of the repairs identified above, but indicated he and the maintenance department rely on staff to communicate repairs.

2. Related to Intake #025703-15:

Resident #017 indicated that he/she was relocated to a room in the attached retirement home, on a specific date due to his/her room being flooded. Resident indicated he/she was relocated for approximately one week while water damage was repaired to walls and flooring in her room. Resident #017 indicated the flooding on the identified date, was not the first flood to have occurred in the room. Resident #017 indicated, that he/she was told, that the flood in the room had occurred due to issues with malfunctioning of the downspouts coming from the roof-top.

Resident #017 indicated that since the incident, the home has relocated the downspouts away from his/her room.

The Environmental Services Manager indicated that the flooding of resident's room (and a second floor resident room) was caused by an eaves trough and down spout being clogged and not functioning properly. Environmental Services Manager indicated that the non-functioning eaves trough and down spout has been since condemned and a new down spout has been established.

During this inspection, an aluminium down spout (a portion of the down spout, approximately nine foot length), located at the front of the home, was observed to be crushed. The aluminium elbow, connected to the crushed down spout, was dripping with water and a puddle of water was observed underneath the elbow.

Family #050 indicated that aluminium down spout located at the front of the home has been damaged (crushed) for approximately one year. Family #050 indicated that water puddles (or ice) accumulate under the elbow of the down spout and at the corner of the home, parking lot and resident smoking area on a regular basis. Family #050 indicated that the water accumulation is due to damaged down spouts and intern poses a potential safety hazard.

3. Related to Intake #029844-15:

Family #048 indicated that the garden patio and courtyard has been in a state of disrepair (cracked and or broken concrete and uneven interlocking bricks) for approximately one year. Family #048 indicated that the garden patio and courtyard disrepair make it difficult for residents and families to use the areas, as such poses a safety (trip and fall) hazard. Family #048 indicated bringing this concern forward to the Administrator and also the now Acting Administrator without resolution to the disrepair. Family #048 indicated that the Family Council has also voiced concerns, specific to the garden patio and courtyard on more than one occasion.

A review of the Family Council Meeting Minutes provides documentation that members of Family Council raised concerns, specific to the disrepair in the courtyard and garden patio, to the Administrator and or Acting Administrator during meetings held January, September and November of 2015.

A letter, on a identified date, was forwarded to the Administrator, by the Family Council, asking about the patio and courtyard repairs; a written response from the Administrator, seven days later, indicated that a contractor would be brought into the home in Spring of 2015 to assess the patio /courtyard issues and provide the home with possible solutions.

During this inspection, sections of the front entrance walkway, resident smoking area, and the courtyard/garden patio were observed to have cracked, chipped and uneven concrete, as well as uneven interlocking patio stones. A portion of the courtyard walk-way was roped off with yellow caution tape.

The Environmental Services Manager indicated that portions of the courtyard were roped off with caution tape, as the tree roots, in this area, were emerging from the earth and causing the walk-way to be uneven. Environmental Services Manager indicated that residents and families were unable to use the roped off section due to safety reasons.

The Acting Administrator indicated that there are currently no plans in place for repair of the garden patio and or courtyard.

4. Related to Intake #007100-15:

Family #050 indicated that his/her family (resident #051) moved into the home approximately a year ago. Family #050 indicated that an electrical outlet/receptacle behind resident #051's bed was damaged, rendering it unusable, since the time of resident #051's admission to the home. Family #050 commented that the electrical outlet/receptacle had not been fixed until the afternoon of January 25, 2016. Family #051 indicated bringing this concern forward on more than one occasion to nursing staff and the Acting Administrator without resolution.

Environmental Services Manager indicated being aware of the damaged electrical outlet; ESM indicted the outlet/receptacle was identified as an issue during a maintenance audit which was conducted November 2015. ESM could not recall why the damaged outlet/receptacle was not fixed.

Environmental Services Manager acknowledged that the electrical outlet/receptacle was not fixed until January 25, 2016.

Administrator and Environmental Services Manager indicated that it would be an expectation the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, but indicated that repairs needed are costly and the hope is to rebuild the home.

Note: LTCHA, 2007, s. 15 (2) (c), was issued as a Voluntary Plan of Correction (VPC) during inspection #2015_330573_0011, which took place April 2015. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

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.

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 19th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Burns

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