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
Dec 8, 2014	2014_267528_0036	H-001482-14	Resident Quality Inspection

Licensee/Titulaire de permis

CLARION NURSING HOMES LIMITED
337 HIGHWAY #8 STONEY CREEK ON L8G 1E7

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

CLARION NURSING HOME
337 HIGHWAY #8 STONEY CREEK ON L8G 1E7

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

CYNTHIA DITOMASSO (528), BERNADETTE SUSNIK (120), CAROL POLCZ (156), DIANNE BARSEVICH (581), IRENE PASEL (510)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 12, 13, 14, 17, 18, 19, 20, 2014

This inspection was done concurrently with Complaint and Critical Incident System Inspection Log #'s: H-000797-14, H-001345-14, and H-001496-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Care, Relief Director of Care(s), Activity Director, Dietary Supervisor, Food Service Manager (FSM), registered nurses (RNs), registered practical nurse (RPNs), physiotherapy assistants (PAs), Registered Dietitian (RD), dietary aides, maintenance, housekeeping staff, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

17 WN(s)
9 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that the lighting requirements set out in the Table to this section were maintained.

Illumination levels were measured in various areas of the home on November 19, 2014, using a hand held portable illumination meter. All efforts were made to reduce natural light from the areas measured by using blinds or drapes. The light meter was held parallel to the floor at a standard 36 inches above the floor. Areas measured included the lower and upper corridors, tub/shower rooms, resident rooms and bathrooms, common bathrooms, activity room, television rooms and lower level dining areas. The upper level dining area and sunroom could not be measured due to excessive natural

light infiltration.

A)Resident Rooms
Not all rooms were equipped with the same light fixtures and rooms varied in size from single, double and quadruple bed rooms. Rooms 101, 103, 109, 110, 112, 202, 203, 204, 209, 210, 211 and 212 were equipped with ceiling fan lights located towards the window in the room. All rooms were equipped with a single bulb, ceiling mounted light inside of a metal tube at the entrance. The majority of the rooms were equipped with ceiling mounted four foot fluorescent tube lights behind a textured clear lens. One single, one double and one quadruple room was measured. Room #101 had a ceiling fan light which was 20 lux directly under. The rest of the room was zero to 20 lux, from the door to the bed and around the foot of the bed. The head of the bed was equipped with an over bed light which was 160 lux with the meter in the area of the head while in a reading position. Room #119 was equipped with a fluorescent tube light on the ceiling between two beds and was 400 lux. However, the area along side of each bed, on the opposite side of the light fixtures was 50-100 lux. One over bed light was measured to be 200 lux. Room #121 had several fluorescent tube lights in the centre of the room. Levels were above the minimum requirement along the path of travel to the beds. The entrance was 20 lux to just before the beds. The over bed light over one bed was 125 lux. The minimum required amount of lux for areas of the room where activity takes place (walking, dressing, eating, sitting in a chair) is 215.28 lux. Over bed lights are required to provide a minimum of 376.73 lux.

B)Lower Level Dining Rooms
Three distinct dining areas were measured, each equipped with recessed pot lights and compact fluorescent light bulbs. The area with several windows was also equipped with four foot fluorescent tube lights. In this particular area, the lux was 100-250 lux between the tables while walking from table to table and over top of several of the dining tables. Pot lights all ranged in level from 100 to 300 lux. The area under the fluorescent tube lights was adequate.

The other dining areas were not equipped with any fluorescent tube lights and it was notably darker. The lux was 50-100 while walking between tables and above tables. Some pot lights were at 200 lux and others at 100 lux. The minimum required lighting level is 215.28 lux in areas of each table and the general walking path to each table.

C)Resident Bathrooms
Each resident bathroom and most common washrooms located in corridors were

equipped with the same light fixture, a round wall mounted fixture with two compact fluorescent bulbs behind an opaque cover over top of the vanity. In some cases, only one bulb was functioning. Only a few random washrooms were measured. The vanity levels ranged from 75-125 lux and the toilet areas ranged from 25-70 lux when both bulbs were functioning. The minimum required level is 215.28 lux.

D)Lounge/Television Room
One lounge at the end of the upper and lower floors was measured. The lounges each had six ceiling flush mounted lights. The lux level while walking around both rooms was 50-100 lux. The minimum required level is 215.28 lux.

According to the licensee, all corridor and bedroom tube lights were replaced with T8 model fluorescent lights in 2013 to increase lighting efficiency. The corridor lights were measured and passed minimum requirements directly under the lighting fixtures, however the level of light between fixtures was at approximately 215 lux. As the bulbs begin to age, the level will begin to drop. A lux lighting assessment was reported to have been completed however the licensee was not able to provide the report at the time of inspection. [s. 18.]

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. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system (RSCRS) that was available in every area accessible by residents.

Activation stations, which are a component of the RSCRS, are used to alert staff when assistance is required. Activation stations were not equipped in the lower and upper dining room areas, upper and lower television rooms, physiotherapy room, activation room, sun room, outdoor patio and balcony. [s. 17. (1) (e)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

s. 90. (3) The licensee shall ensure that the home's mechanical ventilation systems are functioning at all times except when the home is operating on power from an emergency generator. O. Reg. 79/10, s. 90 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures or schedules were in place for routine, remedial or preventive maintenance.

Maintenance services for the home were provided by in-home staff, consisting of one part-time maintenance person and one supervisor. The home's remedial program consisted of various staff from different departments completing a requisition when a repair was needed. Their preventive program consisted of external contractors visiting for various systems such as heating, ventilation, fire systems, boilers, lift equipment and tubs. Written maintenance procedures were reviewed which consisted of procedures for major home systems, but failed to include procedures and schedules for the issues identified below.

A)The home's maintenance procedures titled "Painting" C-90-15 (undated) required that maintenance personnel, on a quarterly basis "inspect all resident rooms, corridors etc" and that they would paint in all required areas and complete touch up painting and plastering. No specific expectations for wall and door condition was indicated and no schedules were developed to ensure that a continuous and routine painting program was in place. According to the maintenance supervisor, walls and doors in resident bedrooms and bathrooms were all painted by an external contractor over the course of the last two years and not quarterly. Some spot painting was completed by the part-time maintenance person. During a tour of the home, heavy scuffing was noted in rooms 106, 107, 115, 121, 221, 222, 219, 208, 207 and minor scuffing in other rooms. The lower floor servery wall next to the hand sink was in poor condition, with no plaster and wall board exposed underneath. The upper shower room had one tile broken (with sharp edges) in the shower area and resident room 212 had four ceramic tiles missing along

the floor/wall junction. Resident rooms 106 & 108 where the electric baseboard heaters were replaced (more than three months ago) were left with unfinished walls (missing baseboards and poor wall condition) on either side of the new heaters.
B)Side metal door casings around most of the bathroom doors located on both the lower and upper floors were observed to be covered in a protective plastic guard. The guards were not in good condition and were either cracked, broken, missing or missing large sections in rooms 224, 219, 208, 121, 105, 108, 107. No audit had been completed to determine the number of guards that needed to be replaced and a schedule established to replace them.
C)Bed side tables located in rooms 119, 116, 115, 113, 114, 108, 107,106, 105, 211, 221, 222, 219, 220, 218, 213, 208, 207, 206, and over bed tables in rooms 221 & 116 were observed to be in poor condition (particle board exposure around top edges). The home's maintenance procedures did not include the expectations for the condition of any resident furniture (beds, bed side tables, chairs, wardrobes, over bed tables), how they would be maintained, by whom and how they would be monitored. No schedules or plans to have the furniture repaired or replaced was in place.
D)Sliding closet doors located in each resident bedroom were in poor condition. The doors, made of a hard cardboard-like material were bent and scuffed and the bottom rollers removed so that they were not connected to the floor track. As a result the doors were able to swing in and outwards and not very secure. According to the licensee, the bottom hardware was disconnected so that damage to the doors from wheelchairs could be minimized. The home's maintenance procedures did not include the expectations for the condition of closet doors, how they would be maintained, by whom and how they would be monitored.
E)Heavily rusted baseboard heaters were identified in rooms 104, 105, 113, 115, 117, 120, 121. The home's maintenance procedures did not include the expectations for the condition of baseboard heaters, how they would be maintained, by whom and how they would be monitored. No schedules or plans to have the heaters resurfaced or replaced was in place.
F)Assist or transfer bars attached to bed frames on beds in rooms 115, 108, 219, 213 were tested and noted to be loose. Beds were repaired as nursing staff report deficiencies (as identified by reviewing repair requisitions) but no routine monitoring for bed condition had been established. No procedures were developed to guide maintenance staff as to manufacturer's requirements or condition expectations.
G)Floor tiles were observed to be cracked in multiple areas of the home, however the tiles were not lifting or coming apart due to a heavy layer of floor wax. However, in rooms 106, 105, 107, 108, areas of the floor were slightly raised, creating a slight hump. According to the maintenance person, the concrete under the tiles had heaved upward.

The worker was aware of how the situation could be resolved. The home's maintenance procedures did not include the expectations for the condition of flooring material, how it would be maintained, by whom and how they would be monitored. No schedules or plans to have the tiles replaced and the uneven flooring repaired was in place.
H)The laminate counter located in the main kitchen next to the stove was in poor condition (bubbled, cracked, missing trim). Repair would be difficult as a large piece of kitchen equipment was located on top and could not be moved without much effort by more than one person. The wooden butcher block counter located in the centre of the kitchen was situated on top of several cabinet bases, one with a rotted kick plate. The home's maintenance procedures did not include the expectations for the condition of kitchen counters and cabinets, how they would be maintained, by whom and how they would be monitored. [s. 90. (1) (b)]

2. The licensee did not ensure that procedures were developed and implemented to ensure that the home's mechanical ventilation systems were functioning at all times except when the home is operating on power from an emergency generator.

The exhaust system for half of the long term care building was not functioning at the time of inspection. The home's maintenance staff were not aware of the failure and were informed on November 19, 2014. No routine procedure to check the exhaust system on a daily basis was in place. [s. 90. (3)]

Additional Required Actions:

CO # - 003 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 that procedures were developed and implemented so that the home's mechanical ventilation systems is functioning at all times except when the home is operating on power from an emergency generator, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents. Non-residential areas include spaces that are strictly for staff use (service corridors, laundry chutes, utility rooms) or where residents would not normally access unless supervised by staff.

The home was constructed with one laundry chute located in a short corridor near the home's zone 5 stairwell. Two chute access points were observed to be accessible to residents, one on each floor. Neither chute room door was equipped with a lock. [s. 9. (1) 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 that a lock is equipped on the doors leading to non-residential areas, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 19. Generators

Specifically failed to comply with the following:

s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).

Findings/Faits saillants :

1. The licensee did not have guaranteed access to a generator.

The home is a "C" classification and was built over 30 years ago without a generator and without a transfer switch in which to connect the generator to the home's power supply. The home is not required to have a permanent generator (and associated connections) on site until December 31, 2016. The licensee was not able to provide any documentation or the name of a generator company or supplier that could deliver a generator to the home when requested. The licensee was aware of the regulatory requirements and stated that they could not meet them as the home was not physically capable of accepting the delivery of a generator or able to connect the portable generator to the home's power supply as it was built without a transfer switch. [s. 19. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1)(a),(b) and (c), to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee did not ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied:
1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

A) Resident #15 was observed sitting in a tilt wheelchair on November 17, 18, 19, 2014. Interviews and review of the clinical record indicated that the after a fall in 2011, the resident required a tilt wheelchair. There was no assessment completed to determine the reason for the use of the device, nor any documented consents or approvals for its use. The Director of Care and registered staff confirmed that the resident was not assessed to determine if the tilt wheelchair was used as a PASD or a restraint nor did they have a documented consent or approval for the device in place.

B) Resident #11 was observed sitting in a tilt wheelchair on November 17, 18, 19, 2014. Review of the clinical record indicated that the resident was admitted to the home with a tilt wheelchair. There was no assessment completed to determine the reason for the use of the device, nor any documented consent or approvals for its use. The Director of Care and registered staff confirmed that the resident was not assessed to determine if the tilt chair was used as a PASD or a restraint nor did they have a documented consent or approval for the device in place. [s. 33. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD has been considered and tried where appropriate.
3. The use of the PASD has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status.

A) On April to September, 2014, resident #20 had monthly weights completed and recorded in the clinical health record.
i. The change in resident's weight from June to September 2014, represented an eight percent change in three months compared and 11.4 percent weight change when compared to April 2014.
ii. As confirmed with the RD on November 19, 2014, a weight change referral to the RD was not initiated. Weight changes were not assessed using an interdisciplinary approach, and actions were not taken and outcomes evaluated.

B) From June to July 2014, resident #21 had three recorded weights documented in the clinical health record.
i. The resident's weight in one month represented a seven percent change and when re-weighed represented a nine percent change in weight.
ii. As confirmed with the RD on November 19, 2014, a weight change referral to the RD was not initiated. Weight changes were not assessed using an interdisciplinary approach, and actions were not taken and outcomes evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system provided for standardized recipes and production sheets for all menus.

The home did not have standardized recipes for all menus. For example, on Week 2 Tuesday, the therapeutic menu indicated that minced canneloni, pureed garlic bread, and minced caesar salad were to be provided, however, recipes were not available to guide staff in food production. The therapeutic menu indicated that minced roasted potatoes and minced tart were to be provided, however, recipes for these items were not available to guide staff in food production. The FSM confirmed on November 19, 2014, that the home was still working on food production and did not have all recipes available. [s. 72. (2) (c)]

2. The licensee failed to ensure that there was a cleaning schedule for: the food production areas, servery areas, and dishwashing areas and that staff comply with this schedule.

During the kitchen walk through on November 19, 2014, it was noted that the side of the oven was very dirty and dusty. The exhaust hood above the stove area was also found to have layers of dirt and dust which could easily be transferred to the food. The kitchen flooring and walls were found to be very dirty and food splashes were found on the walls and side of ice machine and other kitchen equipment. The flooring in the dry storage area under the stairs to the delivery door was found to be in need of cleaning. Weekly kitchen cleaning schedules were provided, however, not all items were signed off or completed. The FSM reported that there was an extra six hours per month for deep clean, however, this was not done as they were short staffed. The licensee did not ensure that staff complied with the cleaning schedules. [s. 72. (7) (c)]

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 the following:
i. that the food production system provides for standardized recipes and production sheets for all menus
ii. To ensure that there is a cleaning schedule for: the food production areas, servery areas, and dishwashing areas and that staff comply with the schedule, to be implemented voluntarily.

WN #9: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were implemented for cleaning the walls and doors in the home.

The home's housekeeping program was contracted out to an external company and consisted of two housekeepers and one supervisor. Their contract required that they clean the home which consisted of two stories, 100 residents, 50 bedrooms, 56 washrooms, several dining rooms, common spaces, utility rooms, corridors, stairwells and offices.

The housekeeping policies and procedures for resident bedroom and washroom cleaning (C-15-25 and C-15-05) dated 12/08/08 required that resident and washroom walls and doors be spot wiped daily. A separate policy for wall washing (C-15-30) required that walls be cleaned yearly or more frequently as required. Walls and doors were visibly soiled over several days in washrooms and bedrooms in but not limited to the following areas: the upper floor t.v. lounge, rooms 115, 224, 221, 222, 219, 216, 214, 208. Discussion with the housekeeping staff and supervisor revealed that staff were aware of the expectations but that they were not able to meet them based on the hours allocated to perform the various duties [s. 87. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are implemented for cleaning the walls and doors in the home, to be implemented voluntarily.

WN #10: 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.

A) On November 18, 2014, during an observation of the medication storage areas, it was noted that controlled substances, awaiting destruction were stored in a single-locked stationary cupboard in the medication rooms on first and second floor. The emergency controlled substance supply was also stored in a single-locked stationary cupboard in the medication room of the second floors. Interview with registered staff confirmed that the controlled substances were stored in a single-locked stationary cupboard only. [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 to ensure that 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, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4).

s. 230. (5) The licensee shall ensure that the emergency plans address the following components:
1. Plan activation. O. Reg. 79/10, s. 230 (5).
2. Lines of authority. O. Reg. 79/10, s. 230 (5).
3. Communications plan. O. Reg. 79/10, s. 230 (5).
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(c) conduct a planned evacuation at least once every three years; and O. Reg. 79/10, s. 230 (7).
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

1. The licensee did not ensure that emergency plans provided for dealing with community disasters (flood, blizzard, road closures, etc.) and chemical spills. [s. 230. (4) 1.]

2. The licensee did note ensure that all of the emergency plans addressed the following components:

1. Plan activation.
2. Lines of authority.
3. Communications plan.
4. Specific staff roles and responsibilities.

The home's required emergency plans related to loss of natural gas, tornado, loss of water, contaminated air and violence in the community (internal) did not have all of the above identified components. [s. 230. (5)]

3. The licensee did not ensure that,
(a)the emergency plans related to the loss of essential services, situations involving a missing resident, medical emergencies and violent outbursts were tested on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency;
(b)all other emergency plans (community disaster, chemical spill, bomb threat) were tested at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency;
(c)a planned evacuation was conducted at least once every three years;
(d)a written record was kept of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans.

According to the Director of Care, a mock evacuation took place on September 11, 2014, however only the upper floor residents were evacuated to an area on the same level. The lower floor residents were not involved in the exercise. This type of evacuation is termed a horizontal evacuation and is tested typically for fire emergencies. A full evacuation of all residents from the home was not tested for other types of situations such as a bomb threat, gas leak or flood. [s. 230. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the emergency plans provide for all specified emergencies, are tested at the specified frequencies, evaluated annually and that documentation is kept as required, to be implemented voluntarily.

WN #12: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) During the course of the inspection, resident #14 was noted to be using a self applied seat belt. Review of the plan of care did not include any indication that the resident required, requested, or preferred the use of the belt. Interview with registered staff confirmed that although the resident applied the belt themselves daily, the plan of care was not updated to include any information related the front fastening seat belt. [s. 6. (1) (a)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee respond in writing within ten days of receiving Family Council advice related to concerns or recommendations in relation to the following;

A) A review of the Family Council Meeting Minutes from January 14, 2014, to October 7, 2014, identified that not all concerns or recommendations received were responded to in writing within ten days.

i. Meeting minutes from May 2014, included a concern from a family member about the cleanliness of residents' closets and ensuring that residents' garbage cans were regularly empty. There was another concern raised about the cleanliness of the chairs and table legs in the main dining room and a request to post RPN assignments outside the medication room so that family knew specifically who to contact regarding an issue with a resident. These concerns were not responded to by the licensee.
ii. Interview with the Family Council Assistant confirmed that written responses to concerns and recommendations were not completed within ten days. [s. 60. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the activities program included the assistance and support to permit the residents to participate in activities that may be of interest to them if they are not able to do so independently.

During interview on November 18, 2014, the activity coordinator indicated that resident # 16 enjoyed music programming. On November 19, 2014, the home offered a music remedy program at 10:30 hours on the first floor. At this time, resident #16 was on the second floor, awake, and sitting in a wheelchair near the nurses station. The activity aide reported that the resident would not be attending the program; that the program was for residents on the first floor but others may attend if they asked. Both the activity coordinator and family of the resident reported that the resident would have enjoyed the program, however, the resident did not receive assistance and support to participate. The licensee failed to ensure that the resident received assistance and support to permit the resident to participate in the activities that may be of interest to them if they are not able to do so independently. [s. 65. (2) (f)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the menu cycle was reviewed by the Residents' Council.

On November 18, 2014, the Activation Coordinator who completed the Resident Council and Food Committee minutes, reported that residents had not been given the opportunity to review the menu cycle. Discussion was held with the FSM on November 19, 2014, to ensure that the menu and menu changes were made for the long term care residents and not retirement home residents. The FSM confirmed that the Resident Council had not reviewed the menu cycle. [s. 71. (1) (f)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 104. Beds allowed under licence

Specifically failed to comply with the following:

s. 104. (1) A licensee shall not operate more beds in a long-term care home than are allowed under the licence for the home or under the terms of a temporary licence issued under section 111 or than are authorized under section 113. 2007, c. 8, s. 104. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home did not operate more beds than were allowed under the licensee for the home home or under the terms of a temporary license issued under section 111 or than were authorized under section 113.

A) On November 13, 2014, in an interview with the management team of the home, it was identified that the home occasionally had provided private pay respite beds using the home's two "Infirmary Rooms" within the Long-Term Care Home. In an interview with the Administrator on November 18 and 20, 2014, it was confirmed that the private pay respite beds were in operation over the home's licensed capacity of 100 beds since July 2010. [s. 104. (1)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept up to date at all times.

A) In 2014, resident # 70 had an unwitnessed fall resulting in transfer to hospital.
i. The home's fall incident report indicated that the resident was immediately assessed, Head Injury Routine Protocol initiated, and was transferred to hospital approximately two hours post fall.
ii. According to the home's Head Injury Routine Protocol, neurological vitals signs were to be assessed every fifteen minutes for the first hour, every hour for three hours, every two hours for eight hours, and every shift for up to three days.
iii. Review of the clinical record did not include documentation of neurological vital signs for the two hours before the resident was transferred to the hospital.
iv. Interview with registered staff confirmed that the resident's neurological status was assessed and documented per protocol, but the home was unable to produce the records. [s. 231. (b)]

Issued on this 9th day of December, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	CYNTHIA DITOMASSO (528), BERNADETTE SUSNIK (120), CAROL POLCZ (156), DIANNE BARSEVICH (581), IRENE PASEL (510)
Inspection No. / No de l'inspection :	2014_267528_0036
Log No. / Registre no:	H-001482-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 8, 2014
Licensee / Titulaire de permis :	CLARION NURSING HOMES LIMITED 337 HIGHWAY #8, STONEY CREEK, ON, L8G-1E7
LTC Home / Foyer de SLD :	CLARION NURSING HOME 337 HIGHWAY #8, STONEY CREEK, ON, L8G-1E7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To CLARION NURSING HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

The licensee shall prepare and submit a plan that summarizes how the lighting levels in the home will be maintained according to the lighting table (under the category identified as "all other homes"), specifically in resident rooms, dining rooms, all washrooms, common lounges and other sitting areas.

The plan shall be emailed to Bernadette.susnik@ontario.ca by March 1, 201. The plan shall be fully implemented by December 31, 2015.

Grounds / Motifs :

1. The licensee did not ensure that the lighting requirements set out in the Table to this section were maintained.

Illumination levels were measured in various areas of the home on November 19, 2014, using a hand held portable illumination meter. All efforts were made to reduce natural light from the areas measured by using blinds or drapes. The light meter was held parallel to the floor at a standard 36 inches above the floor. Areas measured included the lower and upper corridors, tub/shower rooms, resident rooms and bathrooms, common bathrooms, activity room, television rooms and lower level dining areas. The upper level dining area and sunroom could not be measured due to excessive natural light infiltration.

A) Resident Rooms
Not all rooms were equipped with the same light fixtures and rooms varied in size from single, double and quadruple bed rooms. Rooms 101, 103, 109, 110, 112, 202, 203, 204, 209, 210, 211 and 212 were equipped with ceiling fan lights located towards the window in the room. All rooms were equipped with a single bulb, ceiling mounted light inside of a metal tube at the entrance. The majority of the rooms were equipped with ceiling mounted four foot fluorescent tube lights behind a textured clear lens. One single, one double and one quadruple room was measured. Room #101 had a ceiling fan light which was 20 lux directly under. The rest of the room was zero to 20 lux, from the door to the bed and around the foot of the bed. The head of the bed was equipped with an over bed light which was 160 lux with the meter in the area of the head while in a reading position. Room #119 was equipped with a fluorescent tube light on the ceiling between two beds and was 400 lux. However, the area along side of each bed, on the opposite side of the light fixtures was 50-100 lux. One over bed light was measured to be 200 lux. Room #121 had several fluorescent tube lights in the centre of the room. Levels were above the minimum requirement along the path of travel to the beds. The entrance was 20 lux to just before the beds. The over

bed light over one bed was 125 lux. The minimum required amount of lux for areas of the room where activity takes place (walking, dressing, eating, sitting in a chair) is 215.28 lux. Over bed lights are required to provide a minimum of 376.73 lux.

B) Lower Level Dining Rooms
Three distinct dining areas were measured, each equipped with recessed pot lights and compact fluorescent light bulbs. The area with several windows was also equipped with four 4 foot fluorescent tube lights. In this particular area, the lux was 100-250 lux between the tables while walking from table to table and over top of several of the dining tables. Pot lights all ranged in level from 100 to 300 lux. The area under the fluorescent tube lights was adequate.

The other dining areas were not equipped with any fluorescent tube lights and it was notably darker. The lux was 50-100 while walking between tables and above tables. Some pot lights were at 200 lux and others at 100 lux. The minimum required lighting level is 215.28 lux in areas of each table and the general walking path to each table.

C) Resident Bathrooms
Each resident bathroom and most common washrooms located in corridors were equipped with the same light fixture, a round wall mounted fixture with two compact fluorescent bulbs behind an opaque cover over top of the vanity. In some cases, only one bulb was functioning. Only a few random washrooms were measured. The vanity levels ranged from 75-125 lux and the toilet areas ranged from 25-70 lux when both bulbs were functioning. The minimum required level is 215.28 lux.

D) Lounge/Television Room
One lounge at the end of the upper and lower floors was measured. The lounges each had 6 ceiling flush mounted lights. The lux level while walking around both rooms was 50-100 lux. The minimum required level is 215.28 lux.

According to the licensee, all corridor and bedroom tube lights were replaced with T8 model fluorescent lights in 2013 to increase lighting efficiency. The corridor lights were measured and passed minimum requirements directly under the lighting fixtures, however the level of light between fixtures was at approximately 215 lux. As the bulbs begin to age, the level will begin to drop. A lux lighting assessment was reported to have been completed however the

licensee was not able to provide the report at the time of inspection. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee shall install an activation station in the areas identified in the grounds below and any other area identified by the licensee as a resident accessible area. The activation stations shall be installed such that they can be easily seen, accessed and used by residents, staff and visitors at all times and secondly, connected to the resident-staff communication and response system so that when a station is activated, the location is identifiable to staff by both sight and sound.

Grounds / Motifs :

1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system (RSCRS) that was available in every area accessible by residents.

Activation stations, which are a component of the RSCRS, are used to alert staff when assistance is required. Activation stations were not equipped in the lower and upper dining room areas, upper and lower television rooms, physiotherapy room, activation room, sun room, outdoor patio and balcony. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee shall prepare and submit a plan that summarizes the following:

1. When the maintenance procedures for the identified issues A-I will be developed.
2. Who will be designated to complete the audits and develop remedial schedules for all of the issues identified A-H and when will the audits and schedules be completed.
3. Who will complete the repairs for all of the identified issues A-I.
4. Long term maintenance plans to ensure that floors, furnishings, heating equipment, cabinets, counters, exhaust, walls, doors and closets will remain in good working order or in good condition.

The plan shall be emailed to Bernadette.susnik@ontario.ca by January 31, 2015. The plan shall be fully implemented by June 1, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that procedures or schedules were in place for routine, remedial or preventive maintenance.

Maintenance services for the home were provided by in-home staff, consisting of one part-time maintenance person and one supervisor. The home's remedial program consisted of various staff from different departments completing a

requisition when a repair was needed. Their preventive program consisted of external contractors visiting for various systems such as heating, ventilation, fire systems, boilers, lift equipment and tubs. Written maintenance procedures were reviewed which consisted of procedures for major home systems, but failed to include procedures and schedules for the issues identified below.

A) The home's maintenance procedures titled "Painting" C-90-15 (undated) required that maintenance personnel, on a quarterly basis "inspect all resident rooms, corridors etc" and that they would paint in all required areas and complete touch up painting and plastering. No specific expectations for wall and door condition was indicated and no schedules were developed to ensure that a continuous and routine painting program was in place. According to the maintenance supervisor, walls and doors in resident bedrooms and bathrooms were all painted by an external contractor over the course of the last two years and not quarterly. Some spot painting was completed by the part-time maintenance person. During a tour of the home, heavy scuffing was noted in rooms 106, 107, 115, 121, 221, 222, 219, 208, 207 and minor scuffing in other rooms. The lower floor servery wall next to the hand sink was in poor condition, with no plaster and wall board exposed underneath. The upper shower room had one tile broken (with sharp edges) in the shower area and resident room #212 had four ceramic tiles missing along the floor/wall junction. Resident rooms 106 & 108 where the electric baseboard heaters were replaced (more than three months ago) were left with unfinished walls (missing baseboards and poor wall condition) on either side of the new heaters.
B) Side metal door casings around most of the bathroom doors located on both the lower and upper floors were observed to be covered in a protective plastic guard. The guards were not in good condition and were either cracked, broken, missing or missing large sections in rooms 224, 219, 208, 121, 105, 108, 107. No audit had been completed to determine the number of guards that needed to be replaced and a schedule established to replace them.
C) Bed side tables located in rooms 119, 116, 115, 113, 114, 108, 107,106, 105, 211, 221, 222, 219, 220, 218, 213, 208, 207, 206, and over bed tables in rooms 221 & 116 were observed to be in poor condition (particle board exposure around top edges). The home's maintenance procedures did not include the expectations for the condition of any resident furniture (beds, bed side tables, chairs, wardrobes, over bed tables), how they would be maintained, by whom and how they would be monitored. No schedules or plans to have the furniture repaired or replaced was in place.
D) Sliding closet doors located in each resident bedroom were in poor condition.

The doors, made of a hard cardboard-like material were bent and scuffed and the bottom rollers removed so that they were not connected to the floor track. As a result the doors were able to swing in and outwards and not very secure. According to the licensee, the bottom hardware was disconnected so that damage to the doors from wheelchairs could be minimized. The home's maintenance procedures did not include the expectations for the condition of closet doors, how they would be maintained, by whom and how they would be monitored.

E) Heavily rusted baseboard heaters were identified in rooms 104, 105, 113, 115, 117, 120, 121. The home's maintenance procedures did not include the expectations for the condition of baseboard heaters, how they would be maintained, by whom and how they would be monitored. No schedules or plans to have the heaters resurfaced or replaced was in place.

F) Assist or transfer bars attached to bed frames on beds in rooms 115, 108, 219, 213 were tested and noted to be loose. Beds were repaired as nursing staff report deficiencies (as identified by reviewing repair requisitions) but no routine monitoring for bed condition had been established. No procedures were developed to guide maintenance staff as to manufacturer's requirements or condition expectations.

G) Floor tiles were observed to be cracked in multiple areas of the home, however the tiles were not lifting or coming apart due to a heavy layer of floor wax. However, in rooms 106, 105, 107, 108, areas of the floor were slightly raised, creating a slight hump. According to the maintenance person, the concrete under the tiles had heaved upward. The worker was aware of how the situation could be resolved. The home's maintenance procedures did not include the expectations for the condition of flooring material, how it would be maintained, by whom and how they would be monitored. No schedules or plans to have the tiles replaced and the uneven flooring repaired was in place.

H) The laminate counter located in the main kitchen next to the stove was in poor condition (bubbled, cracked, missing trim). Repair would be difficult as a large piece of kitchen equipment was located on top and could not be moved without much effort by more than one person. The wooden butcher block counter located in the centre of the kitchen was situated on top of several cabinet bases, one with a rotted kick plate. The home's maintenance procedures did not include the expectations for the condition of kitchen counters and cabinets, how they would be maintained, by whom and how they would be monitored.

I) The exhaust system for half of the long term care building was not functioning at the time of inspection. The home's maintenance staff were not aware of the

failure and were informed on November 19, 2014. No routine procedure to check the exhaust system on a daily basis was in place.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

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 8th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cynthia DiTomasso

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