Ministry of Health
and Long-Term Care

Ottawa Service Area Office
Performance Improvement and
Compliance Branch
Health System Accountability and
Performance Division
347 Preston Street, 4th Floor
Ottawa ON K1S 3J4

Ministère de la Santé
et des Soins de longue durée

Bureau régional de services de Ottawa
Direction de l'amélioration de la performance et
de la conformité
Division de la responsabilisation et de la performance du
système de santé
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Ontario

Telephone/Téléphone: 613-569-5602
1-877-779-5559
Fax/Télécopieur: 416-327-4486

Date: May 27, 2014

To: Administrator
President, Residents' Council
President, Family Council

Re: **Inspection #:** 2014_365194_0003
Report Date: May 22, 2014
Type of Inspection: RQI

Enclosed is an ***Inspection Report - Public Copy*** for an inspection conducted under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

Individual envelopes addressed to the 'President, Residents' Council', and 'President, Family Council', must be distributed, unopened to the addressee.

This ***Inspection Report – Public Copy*** must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2). A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request.

The report will also be on file with the Service Area Office, Performance Improvement and Compliance Branch, and posted on the Reports on Long-Term Care Homes website
http://www.health.gov.on.ca/en/public/programs/ltc/26_reporting.aspx

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 22, 2014	2014_365194_0003	O-000327-14	Resident Quality Inspection

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PORT HOPE)
20 HOPE STREET SOUTH, PORT HOPE, ON, L1A-2M8

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

CHANTAL LAFRENIERE (194), GWEN COLES (555), MARIA FRANCIS-ALLEN (552), SAMI JAROUR (570), WENDY BERRY (102)

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): April 22, 23,24,25, 29,30, May 1 & 2, 2014

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance Supervisor, Food Service Supervisor, Pharmacist, Unit Coordinator, Housekeeping Manager, Physio Therapist (PT), Registered Dietitian (RD), Program Manager, RAI Coordinator, Residents and Families.

During the course of the inspection, the inspector(s) During the course of the inspection, the inspector(s)conducted a tour of the home, observed the provision of resident care, observed staff to resident interactions, observed infection prevention and control practices, observed meal service, observed medication program/procedures, reviewed clinical health records for identified residents, reviewed meeting minutes Resident Council, reviewed staffing records, education records, maintenance programs, activity and recreation programs, policies related to restraints, personal hygiene and grooming, infection prevention and control, continence management, medication management,skin and wound, falls prevention, prevention of abuse and personal support services.

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
Food Quality
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
Residents' Council
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident 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. 31 (2).

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(a) the device is used in accordance with any requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(e) the resident is restrained only for as long as is necessary to address the risk referred to in paragraph 1 of subsection (2); 2007, c. 8, s. 31 (3).
(f) the method of restraining used is discontinued if, as a result of the reassessment of the resident's condition, one of the following is identified that would address the risk referred to in paragraph 1 of subsection (2):
(i) an alternative to restraining, or
(ii) a less restrictive method of restraining that would be reasonable, in light of the resident's physical and mental condition and personal history; 2007, c. 8, s. 31 (3).
(g) any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s. 31(1) when the plans of care for the following residents did not identify the use of restraining devices

Resident #1027 was observed by the inspector with two 3/4 bed rails up while in bed. The plan of care for Residents #1027 indicates that the resident is at high risk for falls. Bed and chair alarm are used and staff direction is to "respond to STAT" but the plan of care does not identify the use of two 3/4 bed rails as a restraint.

Resident #4243 was observed by the inspector with two 3/4 bed rails up while in bed. The plan of care for Residents #4243 directs under transferring that the resident requires "2 bed-rails up in bed and call bell within reach at all times, as resident may attempt to transfer self on own" but does not identify the bed rails as a restraint.

Inspector observed Residents #13, #14 and #9930 sitting in their wheelchairs with lap belts fastened. Staff interviewed confirmed that residents #13, #14 and # 9930 were unable to unfasten the lap belts on their own. The plan of care for Residents #13, #14 and #9930 did not identify the use of lap belts as a restraint. [s. 31. (1)]

2. The licensee failed to comply with LTCHA, 2007 s. 31(2)4 when a physician's order was not received for residents using a lap belt and bed rail restraints.

Clinical health records for Resident #1027 and #4243 did not have physician's orders for the use of bed rail restraints.

Clinical health records for Resident #1, #14, and #9930 did not have physician's orders for the use of lap belt restraints. [s. 31. (2) 4.]

3. The licensee failed to comply with LTCHA, 2007 s. 31(2)5 when a consent was not obtained by the resident or substitute decision related to restraint use.

The clinical health record for Residents #1027 and #4243 did not have a consent for the use of the bed rail restraints

The clinical health record for Residents #13, #14, and #9930 did not have a consent for the use of the lap belt restraints. [s. 31. (2) 5.]

4. The licensee failed to comply with LTCHA ,2007 s 31(3) when Residents #1027, #4243, #13, #14 and #9930 who had restraints applied did not have the following;

-the device used in accordance with any requirements provided for in the regulations
-the resident monitored while restrained, in accordance with the requirements provided for in the regulations
-the resident released and repositioned, from time to time, while restrained, in accordance with the requirements provided in the regulations
-the resident's condition reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations [s. 31.

(3)]

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. 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. On April 30 and May 01, 2014 illumination levels in resident areas were checked by Inspector 102. A hand held GE light meter was used. The meter was held 3 to 4 feet above the floor surface with all available electric light fixtures turned on within each room. Window coverings were closed when light levels were measured in residents' bedrooms. Levels of illumination throughout 2nd and 3rd floor residents' bedrooms, which in some bedrooms also includes alcoves, ranged from less than 50% to 75% of the required lighting level of 215.28 lux throughout the majority of the bedroom. Lighting levels were compliant in close proximity to wall mounted lighted fixtures and underneath most ceiling light fixtures.

Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments; to conduct assessments; to provide treatments. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility and overall quality of life. [s. 18.]

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 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 ensure that the home's equipment, walkers and wheelchairs

are kept clean and sanitary.

Resident #4220 was observed with a soiled wheelchair on April 22 and 29, 2014
Resident #4275 was observed with a soiled walker on April 22 and 29, 2014
Resident #10 was observed with a soiled wheelchair on April 29 and 30, 2014

RPN #116 verified that the home has a schedule in place for the cleaning of ambulation equipment, the schedule is designed to have equipment cleaned twice a month. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007 s. 15(2)(c) when furnishings and equipment were not maintained in a safe condition and a good state of repair:
-floor coverings were damaged in the 2nd floor central bathing area: shower floor ripped and lifting in 2 areas; ripped, peeling and soiled duct tape across the threshold strip across the doorway at the entrance to the bathing room. The textured floor surface within this bathing room was also visibly soiled. Non intact floor coverings are a potential safety risk and can not be properly cleaned.
-the floor covering is lifting in the doorway leading into room 209's washroom which is a potential tripping hazard; a gap is evident at the floor wall juncture in room 218's washroom which is difficult to clean and prevent the build up of moisture and debris
-seams are lifting from floor coverings in the 2nd floor shower room and 2nd floor central bathing room exposing gaps in the floor surface
-windows seals are damaged as evidenced by moisture build up causing fogging and staining between window panes in several areas preventing residents from having a clear view to the outside: room 302 (1 window); 2nd floor common room (1 window); 3rd floor dining room (1 window); north end of 3rd floor corridor (1 window)
-during the inspection on April 30 and on May 01, 2014 water was observed leaking from the base of the sliding glass doors in the 2nd floor common room and from the top of the window frame in bedroom 211. In both areas water had pooled on the floor surface presenting a potential safety risk.
-window coverings were damaged and/or missing in the 2nd and 3rd floor common rooms that are also used for dining compromising resident comfort (raised by Residents' Council)
-in the 2nd and 3rd floor central bathing areas, hanger mounts for shower heads will not hold the shower heads in place
-some of the light fixtures, including moisture proof fixtures, are missing covers in the vicinity of bathing fixtures in 2nd and 3rd floor central bathing areas presenting a potential safety risk

-the finish around the side entry bath tub's drain is cracked and chipped in the 3rd floor bathing area across from room 323 presenting a potential cross infection risk
- a number of bed rail covers that were in use had non intact surfaces presenting a potential cross infection risk
-surface veneer was damaged on many bedside tables, free standing wardrobes, on some head boards and foot boards of beds and from desk and counter surfaces at the 2nd floor nurses station and the adjacent counter area. Non intact surfaces can not be adequately cleaned and disinfected as needed presenting a potential infection control risk. Damaged surfaces may also present a safety risk for residents with fragile skin.
- end caps are missing from corridor hand rails in a number of areas on the 2nd and 3rd floors.

Not maintaining the home, furnishings and equipment in a safe condition and a good state of repair presents potential risks to the health, comfort, safety and well being of residents. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg s. 15(1)(b) when steps were not taken to prevent resident entrapment with bed rails, taking into consideration all potential zones of entrapment.

O. Reg. 79/10, s.15(1)(a) identifies that where bed rails are used, the resident is to be assessed and his or her bed system is to be evaluated in accordance with prevailing practices, to minimize risk to the resident. Evidence based prevailing practices are identified in Health Canada's guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", effective date 2008/03/17.

During an inspection in the home on by Inspector 102 on April 29, 30 and May 01, 2014 full length, chrome type bed rails with a potential zone of entrapment within the inner perimeter of the rails were identified to be in use on 8 residents' beds. Partial padded covers were in use on several of the identified bed rails; however, the covers did not fully cover potential entrapment zone openings. Residents were observed laying in a number of the identified beds with rails in the "up" position.

During the inspection, management staff of the home provided written documentation identifying that a bed system evaluation had been conducted on June 09, 2011. A copy of the 4 page report titled "Facility Entrapment Inspection Sheet" was provided to the inspector. The report identified more than 24 beds with entrapment zone failures. Staff of the home confirmed that adjustments were subsequently made to some of the beds and that a number of beds were replaced. Evidence of a follow up evaluation of the bed systems was not provided. At the time of this inspection, all necessary steps had not been taken to minimize risk to residents taking into consideration all potential zones of entrapment, placing residents at risk of harm from entanglement in or around the bed rails. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

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

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 229(4) when all staff did not

participate in the implementation of the Infection prevention and control program.

Review of the licensee's "Outbreak Management Surveillance" Policy " ICM-DUR-005 directs;
Clinical case definitions for respiratory tract outbreak:
-Two cases of acute respiratory tract illness occurring within 48 hours in a geographical area (eg unit, floor) or
-More than one unit having a case of acute respiratory illness within 48 hours
The policy defines Upper Respiratory Tract Illness(including common cold, pharyngitis)
-the resident must have at least 2 of the following (new) symptoms:
-runny nose or sneezing
-stuffy nose(ie congestion)
-sore throat or hoarseness or difficulty swallowing
-dry cough
-swollen or tender glands in the neck (cervical lymphadenopathy)
-fever/abnormal temperature for the resident may be present, but is not required
-for suspected influenza outbreaks you may also consider adding the following symptoms: tiredness, malaise, muscle aches (myalgia) loss of appetite, headache, chills.
The licensee's policy "Elements of Surveillance" ICM-SUR-005 directs, the following in the event of a potential or confirmed outbreak
Notify the local Medical Officer of Health or Designate at your Health Unit of the Potential or confirmed Outbreak
-Provide the Medical Officer of Health or designate with an updated line listing. Note: do not wait until the line listing is completed to notify the MOH.
Review of the home's line listing for the period of April 8 - April 25, 2014 was completed.
-April 17, 2014
-Resident # 16 is identified as having nasal congestion, hoarseness and a dry cough
-Resident # 4293 is identified (in the progress notes) as having a congested cough and an elevated temperature
April 20 2014
-Resident # 2 is identified as having hoarseness and a dry cough
-Resident # 16 is identified as having hoarseness, dry cough and a temperature
-Resident # 1 is identified as having hoarseness, dry cough, temperature and wheeze/rales
-Resident # 20 is identified as having hoarseness, dry cough and temperature

-Resident # 17 is identified as having hoarseness, dry cough
-Resident # 4243 is identified as having nasal congestion, sore throat, and hoarseness
April 22, 2014 two additional resident were identified in the line listing
-Resident # 5765 is identified as having nasal congestion, dry cough
-Resident # 4 is identified as having sore throat, hoarseness and a dry cough
Another unit:
No line listing available for the period of April 20, 2014 to April 25, 2014
April 21, 2014
-Resident #7132 is identified (in the progress notes) as having a hoarse voice, coughing, sneezing and complaints of a sore throat and generally not feeling well.
DOC confirmed that Medical Officer of Health or designate had not been notified of the potential outbreak and was not provided with the current line listing

During observation of tray service on April 22, 2014 Residents #1, 2, 3, 4, 4293, 4243 were seated and being served lunch on portable tables in the hallway. Interview with Staff #101 confirmed that residents were seated in the hallway related to being on isolation precautions and unable to be served lunch in main or in the unit dining room.
- Staff #102 was observed assisting to feed a resident in hallway with no Personal Protective Equipment (PPE) in place. Staff #102 confirmed that the resident was being served lunch in hallway related to being on droplet precautions. Staff #102 reported droplet precautions required PPE within 10 feet of the resident. When asked if her seated position was less than 10 feet from the resident the staff replied yes, then applied PPE and continued assisting resident with the meal.
- When residents are seated in hallway on droplet precautions for meals, it does not allow for the 10 feet radius for other's to pass.
- A co- resident was observed sitting on a walker talking with a resident seated at a portable table in the hallway(for droplet precautions) the co- resident on walker was not wearing PPE. [s. 229. (4)]

2. The licensee failed to ensure that each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

The home's immunization policy, RCSM S-15 indicates "Screening for Tuberculosis will be done for all residents upon admission according to the Ministry of Health

guidelines. Two step mantoux skin test will be completed within 14 days of admission."

Interview with Director of Care indicated that TB screening is completed for resident's within 14 days of admission.

Review of health records for Residents #2680, 4297 and 7132 indicated residents #2680 and resident # 4297 were not screened for tuberculosis within 14 days of admission. Resident #2680 was admitted received a TB skin test stage 1, 26 days later. Resident #4297 was admitted and received a TB skin test stage 1, 21 days later. [s. 229. (10) 1.]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s.8(3) when at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was not on duty and present in the home.

On April 22, 2014 the Administrator informed the inspector that the RN nights position had recently become vacant.

On April 25, 2013 the DOC informed the inspector that Agency staff had been confirmed to fill the RN Night position starting April 28, 2014

On April 29, 2014 the inspector was provided documentation confirming 5 night shifts where no RN was on duty.

On April 29, 2014 the DOC confirmed that the RN nights position had been posted internally, ads had been placed in the local paper and that an ad in "Health Force Ontario" had been posted as well. To date no applications have been received for the position. [s. 8. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home, to be implemented voluntarily.

WN #7: 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).

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).

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. During the inspection on May 02, 2014 the door alarm system was set to by pass and did not activate on two resident accessible doors on the lower level of the home:
-north corridor door to the outside
-central door from the corridor to a stairway.
Staff present on the lower level were not aware that the doors were on by pass. The audio visual enunciator at the nursing station on 2nd floor was continuously illuminated next to doors identified as "1st floor centre stair' and "exit north hall". The alarms for the identified doors were removed from bypass upon notification to staff. [s. 9. (1)]

2. During the inspection by Inspector 102 on April 29th, 2014, the sliding glass door leading from the 2nd floor dining room to the 2nd floor balcony was not able to be locked. The latch on the door could not be engaged. The door is not equipped with a lock that is capable of restricting unsupervised resident access to the balcony.

The door latch on the sliding glass door is malfunctioning. The latch can be engaged if lined up in a specific position. The latch set is worn and is not in a good state of repair. [s. 9. (1) 1.1.]

3. During the inspection on April 29, 2014 by Inspector 102, doors leading to the following non residential areas were all open, not lockable and accessible to residents without supervision by staff:
- doors leading to laundry chutes located within unlocked bathing rooms on 2nd and 3rd floor floors;
- the separation door leading from the lower floor corridor to the service wing area. Sign is posted adjacent to the door that states "Authorized staff only in this area".

Noted that doors leading to the laundry chutes were observed to have been equipped with locks on April 30, 2014.

During the inspection on April 30, 2014 one of the two the doors leading into the laundry room was unlocked and the room was not supervised by staff at 2:30 pm. Potentially hazardous equipment, chemicals and high heat clothing labeler are located within the laundry room. [s. 9. (1) 2.]

4. The licensee has not ensured that there is a written policy pertaining to doors leading to secure outside areas that must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The Director of Resident Care confirmed that there is no policy in place at the home. [s. 9. (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 by ensuring that door leading outdoors are equipment with locking devices that are capable of restricting unsupervised resident access, that alarm systems for doors are not deactivated and ensuring that non residential areas in the home are kept inaccessible to resident's, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s. 29(1)(b) when the policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with the Act and the Regulations was not complied with.

The licensee's Policy "Least Restraint Policy- physical restraints" RSL-SAF-035 describes a physical restraint;
Physical - Device used to inhibit freedom of physical movement and which cannot be removed by the resident on command. Types of permitted physical restraints include:
-safety belts (if resident unable to release buckle on command) used for the prevention of falls or injury that inhibit the normal freedom of movement or ambulation
-full or 3/4 side rails used for the prevention of falls or injury that inhibit normal freedom of movement or ambulation

Prohibited devices that limit movement include:
-any device used to restrain a resident to a commode or toilet

PROCEDURE:
-The decision to apply a restraint will be made in consultation with the resident/POA, with informed consent given in writing. The resident /POA will be provided with a copy of the informed consent.
-A physician's order must be obtained prior to the application of the restraint
-The physician's order for the use of restraints will include: the type of restraint, purpose of use and frequency of use.
-The restraint must be applied by qualified staff as per manufacturer's specifications and hourly checks will be performed and documented, reflective of time of application, removal, re-application and the resident's response. Repositioning(full release of the restraint device and physical weight off loading and shifting) will occur every two hours at minimum. Registered staff will evaluate the continued use of restraints as well as the resident's response each shift at minimum, reflected in the restraint documentation record.
-The ongoing use of the restraint will be evaluated at least quarterly by registered staff, documented in the multidisciplinary progress notes, plan of care and RAPS and the initial and annual care conference notes.

On April 22, 23, and 24, 2014 it was observed that three commode chairs on the 2nd floor tub room and two commode chairs in the 3rd floor tub room were equipped with seat belts. Interview with RN #115 on April 22, 2014 confirmed that the commode

chairs on the 2nd floor tub room where used by staff as commode chairs. Interview with Resident #5397 on April 23, 2014 confirmed staff were using a seat belt when using the commode chair with the resident. Interview with PSW #108 confirmed that when residents were toileted on a commode chair, seat belts would be used if a resident was using a seat belt in their wheelchairs.

On April 30, 2014 Resident #1027 was observed lying in bed in a lateral position with two 3/4 side rails up. The clinical health record did not have a physician's order or a consent for the use of the bed rail restraint. There was no restraint documentation record in place for this resident for April or May 2014. The resident's plan of care indicates that the resident is at high risk for falls. Bed and chair alarm are used and staff direction is to "respond to STAT" (552)

During the observation period of April 22 - May 2, 2014 Resident #4243 was observed in bed with two 3/4 rails up. The clinical health record did not have a physician's order or consent for the use of the bed rail restraint. There was no restraint documentation record in place for this resident for April or May 2014. The resident's plan of care under transferring directs that the resident requires "2 bed-rails up in bed and call bell within reach at all times, as resident may attempt to transfer self on own"

On May 02, 2014 Resident #13 was observed in the dining room wearing a front closing seat belt. The resident was unable to unfasten the seat belt when asked by the inspector. PSW #122 confirmed that the resident was unable to unfasten the seat belt. Review of the clinical health record confirmed that there was no physician's order or consent for the seat belt restraint for this resident. There was no restraint documentation record in place for this resident for April or May 2014. The plan of care for Resident #13 does not identify the use of a seat belt restraint. RPN #100 has stated that there are no restraints in use at this time on the 3rd floor unit, the RPN stated that Resident #13 should not have had a seat belt applied. Review of the Daily Flow Sheet for Resident #13 for the period of March 16 to March 25, 2014 indicates a "check" that the seat belt was applied for 16 shifts.

On May 02, 2014 Resident #9930 was observed in the dining room wearing a front closing seat belt. The resident was unable to unfasten the seat belt when asked by the inspector. RN #129 stated that the resident was wearing a seat belt related to sliding around in the chair. Review of the clinical health record confirmed that there was no physician's order or consent for the seat belt restraint for this resident. There was no restraint documentation record in place for this resident for April or May 2014.

The plan of care for Resident #9930 under "aids to daily living" directs staff to; check resident's safety devices; seat belt, attached table, roll bars. RPN #100 has stated that there are no restraints in use at this time on the 3rd floor unit. Review of the Daily Flow Sheet for Resident #9930 for the period of March 16 to March 31, 2014 indicates a "check" that the seat belt was applied for 16 shifts.

On May 02, 2014 RN #129 and RPN #100 confirmed that Resident #14 had a seat belt in place when in the geri chair and that the resident is unable to unfasten the device. Review of the clinical health record confirmed that there was no physician's order or consent for the seat belt restraint for this resident. There was no restraint documentation record in place for this resident for April or May 2014. The plan of care for Resident #14 does not identify the use of a seat belt restraint. RPN #100 has stated that there are no restraints in use at this time on the 3rd floor unit. Review of the Daily Flow Sheet for Resident #14 for the period of March 16 to March 26, 2014 indicates a "check" that the seat belt was applied for 21 shifts. [s. 29. (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 by ensuring that the home complies with it's policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with the Act and the Regulations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg s.72(3)(b) when all food and fluids in the food production system were not prepared and served using methods to prevent adulteration, contamination and food borne illness

During the inspection on May 01, 2014 egg sandwiches were observed to be stored on china plates directly on the top shelf of the steam table that was present in resident dining area during the mid day meal service. It was confirmed by dietary staff member who was plating the foods, that the egg sandwiches were available to be served to residents, if needed as an alternate choice.

The inspector checked the temperature of the sandwiches by inserting a sanitized probe thermometer into the contents. The temperature of the egg mixture was 13 degrees Celsius at approximately 12:16 pm.

The Food Services Manager was notified of the potential food safety risk and that potentially hazardous food products intended to be served cold must be maintained at a maximum temperature of 4 degrees Celsius or less.

During the inspection on May 01 and May 02, 2014 open jugs containing milk and pre-poured uncovered plastic drinking cups of milks and juices were placed on lower level dining room tables in advance of the meal service. The beverages are exposed to potential contamination and temperature breach.

The licensee did not ensure that all foods and fluids are prepared, stored and served using methods to prevent adulteration, contamination and food borne illness. [s. 72. (3) (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 by ensuring that all food and fluids in the food production system are prepared, stored and served using methods to prevent adulteration, contamination and food borne illness, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s.86(2)(b) when measures to prevent the transmission of infections were not in place

Cross infection risks observed during inspection of home:
-communal use nail clippers attached to a chain in the 3rd floor central tub room. Build up of dried nails under the blades.
-storage of base cryogenic liquid oxygen cylinders and oxygen concentrators in communal use bathing rooms on the 2nd and 3rd floor.
-one residents' clothing stored in communal shower room on 2nd floor: on back of bathing room door and piled in corner by shower cabinet
-many over bed light pull cords were observed to be soiled
-many activator cords for the resident staff communication and response system were laying on the floor in residents' washrooms.
-the blue colored (barbicide) disinfecting solution present inside a cupboard in the hair salon had debris present, along with combs immersed in the glass container which indicates the combs are not being cleaned prior to immersion and the solution is not being used according to directions.
-unlabeled plastic urinals, basins, bed pans and urine measures, some visibly soiled, were present in a number of shared use ensuite residents' washrooms
-mesh back shower and/or commode chairs were observed in a number of shared use areas with small amounts of urine-like residue evident within the plastic containers attached to the undersides of the seats
-during the mid day meal time, residents with identified respiratory symptoms were provided their meals outside bedroom doorways in various locations in the 2nd and 3rd floor corridors. This was observed on multiple days during the inspection period. The Director of Resident Care identified that the provision of meal service in the corridors was the usual practice in this home in order to provide supervision to the affected residents during meal times
- during the inspection by inspector 102 on May 01, 2014, uncovered plastic jugs of

milk were observed on lower level dining room tables in advance of and during the mid day meal service; prepoured, uncovered beverages (milk, juice) had also been placed out on the lower level dining room tables in advance of the arrival of the intended recipient.
- torn and/or damaged and/or visibly soiled foam type arm rest covers are present on toilet risers in 4 washrooms.
- clean face cloths and peri cloths were stored directly on a soiled window sill in the 2nd floor central tub room.

All of the above are potential cross infection risks to residents. Measures are not in place to prevent the transmission of infections. [s. 86. (2) (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 by ensuring that measures are in place at the home to prevent the transmission of infection, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 112(5) when prohibited restraining devices were in use at the home.

During a tour of the building on April 22, 2014 3 commode chairs with seat belts were observed on the 2nd floor tub room. RN# 115 was asked if this chairs were used as commodes for resident's on the unit the RN that yes they were. Tour of the building on April 23, 2014 it was also observed that commode chairs with seat belts were in the 2nd and 3rd floor tub rooms. All seat belts were removed from commode chairs on April 25, 2014.

Interview with PSW #108 was conducted on April 28, 2014 related to the use of seat belts while toileting residents on commode chairs. The PSW stated that if the resident required a seat belt in a wheelchair then a seat belt would be applied to the commode chair stating the resident would not be left unattended while on the commode.

Observed in an identified resident bedroom a commode chair with seat belt attached. Interview with Resident #5397 on April 23, 2014 who indicated commode chair is being used for resident as a commode and staff will often apply seat belt during toileting. Observed on April 25, 2014 seat belt had been removed. [s. 112. 5.]

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 by ensuring that resident's are not restrained while on the commode or toilet., to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure Resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

On April 29, 2014, inspector #552, during the observation of the medication pass witnessed the registered nursing staff discarding empty medication pouches with the following personal health information stamped on them, into clear plastic bag in the bin of the medication cart.

- these plastic pouches contained the name and room number of the residents as well as the name and dosage of the medication being administered
- RPN #100 and DOC confirmed that the plastic bags are then disposed into the regular garbage [s. 3. (1) 11. iv.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The plan of care for Resident #4297 directs that the resident is to wear non-slip well fitting shoes.

On April 24, 2014 at 1429 hours Resident #4297 was observed not wearing well fitting shoes.

On April 28, 2014 RPN #105 was not aware of any issue with the resident not wearing shoes.

On April 28, 2014 PSW #128 confirmed assisting resident# 4297 to get up. PSW #128 stated the resident was offered to have shoes applied, but the resident did not respond. Staff #128 was unaware if the resident had any shoes.

On April 29, 2014 PSW #124 indicated that resident's shoes did not fit, stating that slippers did not fit two weeks ago. [s. 6. (7)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Review of the licensee's "Outbreak Management Surveillance" Policy " ICM-DUR-005 directs;
Clinical case definitions for respiratory tract outbreak:
-Two cases of acute respiratory tract illness occurring within 48 hours in a geographical area (eg unit, floor) or
-More than one unit having a case of acute respiratory illness within 48 hours
The policy defines Upper Respiratory Tract Illness(including common cold, pharyngitis)
-the resident must have at least 2 of the following (new) symptoms:
-runny nose or sneezing
-stuffy nose(ie congestion)
-sore throat or hoarseness or difficulty swallowing
-dry cough
-swollen or tender glands in the neck (cervical lymphadenopathy)
-fever/abnormal temperature for the resident may be present, but is not required
-for suspected influenza outbreaks you may also consider adding the following symptoms: tiredness, malaise, muscle aches (myalgia) loss of appetite, headache, chills.
The licensee's policy "Elements of Surveillance" ICM-SUR-005 directs, the following in the event of a potential or confirmed outbreak
Notify the local Medical Officer of Health or Designate at your Health Unit of the Potential or confirmed Outbreak
-Provide the Medical Officer of Health or designate with an updated line listing. Note: do not wait until the line listing is completed to notify the MOH.
Review of the home's line listing for the period of April 8 - April 25, 2014 was completed.
-April 17, 2014
-Resident # 16 is identified as having nasal congestion, hoarseness and a dry cough
-Resident # 4293 is identified (in the progress notes) as having a congested cough and an elevated temperature
April 20 2014
-Resident # 2 is identified as having hoarseness and a dry cough
-Resident # 16 is identified as having hoarseness, dry cough and a temperature
-Resident # 1 is identified as having hoarseness, dry cough, temperature and wheeze/rales
-Resident # 20 is identified as having hoarseness, dry cough and temperature
-Resident # 17 is identified as having hoarseness, dry cough
-Resident # 4243 is identified as having nasal congestion, sore throat, and

hoarseness
April 22, 2014 two additional resident were identified in the line listing
-Resident # 5765 is identified as having nasal congestion, dry cough
-Resident # 4 is identified as having sore throat, hoarseness and a dry cough
Another Floor:
No line listing available for the period of April 20, 2014 to April 25, 2014
April 21, 2014
-Resident #7132 is identified (in the progress notes) as having a hoarse voice, coughing, sneezing and complaints of a sore throat and generally not feeling well.

During interviews with RN #104 and RPN #100 and DOC it was confirmed that the home surveillance practice is to list residents with symptoms on the 24 hour line listing.

DOC confirmed that the Medical Officer of Health or designate had not been notified of the potential outbreak and was not provided with the current line listing as directed by the policy. [s.8.(1)](194) [s. 8. (1)]

2. The licensee failed to comply with it's policy for resident weight monitoring when the Registered Dietitian (RD) was not informed of Resident #4221's weight loss.

Under the policy of resident weight monitoring (policy # RCSM C-25), The Food Service Supervisor FSS, Physician and RD must be informed of weight loss which meets critical criteria. The Critical weight loss or gain that requires immediate intervention include:
- 5% of total body weight in one month
- 7.5% of total body weight in three months.
- 10% of total body weight in six months.
- 2.2 Kg. in one month.
- 4.5 Kg. over three months.

Resident #4221's weight in an identified month was 62.9 Kg compared to 66.1 Kg the previous month indicating a loss in body weight of 3.2 Kg in one month. The loss of 3.2 Kg exceeds the 2.2 Kg threshold and is considered a critical weight loss as outlined in the licensee's policy of resident weight monitoring.
Record review for Resident #4221 indicated no referral was sent to Registered Dietitian and no interventions put in place to address the drop in resident's body weight in an identified month.

On April 29, 2014: RN staff #104 indicated that a reweigh and referral to Registered Dietitian should have been done. Staff #104 could not confirm that a reweigh or a referral had been completed.
On May 1, 2014: Registered Dietitian #125 confirmed to inspector that a referral regarding weight loss was not received for Resident #4221. [s. 8. (1) (a),s. 8. (1) (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s. 12(2)(e) when a comfortable easy chair was not provided for every resident in the resident's bedroom

Observation conducted by inspectors #570 and #194 noted that the following rooms did not have easy chair in resident's rooms

Room #320, 4 bed room, no chair
Room #319, 4 bed room, no chair
Room #218, 4 bed room, no chair
Room #219, 4 bed room, no chair
Room #223, 2 bed room, no chair
Room #224, 2 bed room, no chair
Room #301, 2 bed room, no chair [s. 12. (2) (e)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s. 13 when every resident bedroom occupied by more than one resident did not have sufficient privacy curtains to provide privacy

Four bedrooms occupied by more than one resident do not have sufficient privacy curtains to provide privacy. [s. 13.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s. 16 when windows in the home that open to the outdoors and were accessible to residents could be opened more than 15 centimeters.

On April 22, 2014 during the initial tour of the home it was observed that windows in the hallways and dining rooms of the 2nd floor and 3rd floor could be opened to greater than 15 centimeters.

On April 23, 2014 all windows in the home on the 2nd and 3rd floor hallways and dining rooms had been restricted to open to no greater than 15 centimeters. [s. 16.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 22. Every licensee of a long-term care home shall ensure that all plumbing fixtures in the home with hose attachments are equipped with a back flow device. O. Reg. 79/10, s. 22.

Findings/Faits saillants :

1. All plumbing fixtures in the home with hose attachments are not equipped with a back flow device:
- spray hose connected to the sink in the hair salon
- spray hose connected to the plastic laundry type sink located in the central 3rd floor tub room [s. 22.]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s. 57(2) when a response to resident concerns were not received in writing within 10 days of being received.

In an identified month Resident Council minutes identified a concern. Two months later Resident Council minutes continue to identify this same issue.

The Housekeeping manager stated during an interview that issues are managed in an informal manner when concerns are brought forward at Residents' Council meetings. The residents are informed at the initial meeting of steps to rectify or measures are discussed at the next meeting.

The Resident Council President confirmed that no written response was received by the licensee related to the concern identified in an identified month or the repeat concern two months later at Resident Council Meetings. [s. 57. (2)]

WN #20: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s. 76(2) when a PSW #130 was performing responsibilities prior to receiving training in the following areas:
-The Resident's Bill of Rights
-The long-term care home's mission statement
-The long-term care homes policy to promote zero tolerance of abuse and neglect of resident
-The duty under section 24 to make mandatory reports
-The protections afforded by section 26
-The long-term care home's policy to minimize the restraining of residents
-Fire prevention and safety
-Emergency and evacuation procedures
-Infection prevention and control
all acts, regulations, policies of the ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities

DOC has confirmed that PSW #130 was hired on an identified date in a casual position.

PSW #130 was interviewed by inspector #194. The PSW confirmed being recently hired at the home and to the date of this inspection had not been provided any education related to abuse or restraints.

The DOC confirmed that the PSW #130 had not received mandatory education prior to performing duties in the home. [s. 76. (2)]

WN #21: 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).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s. 85(3) when it did not seek advice from the Residents' Council in developing and carrying out of the satisfaction survey.

Resident Council President stated that the Residents' Council had not been involved in the development of the satisfaction survey at the home.

Interview with the Administrator confirmed that the satisfaction survey is developed and carried out without seeking advice from the Residents' Council [s. 85. (3)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg s 113(a) and (b) when monthly evaluation of restraints was not completed and an annual evaluation of the effectiveness of the restraint policy was not completed

During the Resident Quality Inspection (RQI) three residents were observed in lap belt restraints and two residents were observed with side rail restraints.

During an interview with inspectors the DOC stated that there were no restraints in the home at this time. DOC confirmed that monthly assessment of restraints was not being completed and also noted that annual evaluations of programs had not been completed in 2013. [s. 113. (a)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

During an interview RPN #100 explained the home's practice for the disposal of non narcotic medications.

- non narcotic medications are discarded in a bin in medication storage room
- completed by pharmacist who visits every week
- some of the medications are still in the plastic pouch
- the medication is placed in a stericycle bin
- no substance or action taken to alter or denature medications

This was practice was confirmed Pharmacist and the DOC

During the observation of the drug storage room, the medications for destruction were observed in their plastic pouches in the bin [s. 136. (6)]

Issued on this 23rd day of May, 2014

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

Chantal Lafrenière #794

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) :	CHANTAL LAFRENIERE (194), GWEN COLES (555), MARIA FRANCIS-ALLEN (552), SAMI JAROUR (570), WENDY BERRY (102)
Inspection No. / No de l'inspection :	2014_365194_0003
Log No. / Registre no:	O-000327-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 22, 2014
Licensee / Titulaire de permis :	COMMUNITY LIFECARE INC 1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6
LTC Home / Foyer de SLD :	COMMUNITY NURSING HOME (PORT HOPE) 20 HOPE STREET SOUTH, PORT HOPE, ON, L1A-2M8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	NANCY JORDAN

Ontario

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

To COMMUNITY LIFECARE INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the following measures are in place for residents who are restrained by a physical device.

-the physical restraint is identified in the resident's written plan of care
-a physician's order is obtained for the restraint in accordance with O. Reg. 79/10 s.110(2)1
-a consent is obtained for use of the restraint from the resident or substitute decision maker (SDM), in accordance with O. Reg. 79/10 s.110(7)4
-the resident is monitored, reassessed, repositioned and the effectiveness of the use of the restraint is evaluated in accordance with O. Reg. 79/10 s.110(2)(3)(4)(5)(6)
-a monthly analysis of the restraining of residents by use of a physical restraint and an annual evaluation to determine the effectiveness of the licensee's restraint policy in accordance with O. Reg. 79/10 s.113(a)(b)(c)(d)(e)

The licensee will provide a written plan by June 10, 2014.

This plan must be submitted in writing to the MOHLTC, Attention: Chantal Lafreniere, Fax (613)569-9670.

Grounds / Motifs :

1. The use of bed rails restraints for Resident #1027 and #4243 and lap belt restraints for Resident # 13, #14, and # 9930 was observed by inspectors and confirmed by staff.
Review of the plan of care for Resident #1027 indicates that the resident is at high risk for falls. Bed and chair alarm are used and staff direction is to

"respond to STAT" , but the plan of care does not identify the use of two 3/4 bed rails as a restraint.
Review of the plan of care for Resident #4243 directs under transferring that the resident requires "2 bed-rails up in bed and call bell within reach at all times, as resident may attempt to transfer self on own" but does not identify the bedrails as a restraint
Review of the plan of care for Resident #13, #14, and #9930 did not identify the use of lap belts as a restraint. Staff interviewed confirmed that residents #13, #14 and # 9930 were unable to unfasten the lap belts on their own.
Review of the clinical health records for Resident #1027 and #4243 did not have physician's orders for the use of bed rail restraints. The clinical health records for Resident #1, #14, and #9930 did not have physician's orders for the use of lap belt restraints.
Review of the clinical health records for Residents #1027 and #4243 did not have a consent for the use of the bed rail restraints. The clinical health records for Residents #13, #14, and #9930 did not have a consent for the use of the lap belt restraints.
Review of the clinical heath records for Residents #1027, #4243, #13, #14 and #9930 was completed. There is no evidence that documentation for the time of application, assessments, reassessments, monitoring and release of the restraint including the resident's response was completed. There is no evidence that documentation for the restraint removal or discontinuance of the device, including time of removal or discontinuance and the post restraining care is documented.

During an interview with inspectors the DOC stated that there were no restraints in use at the home at this time. DOC confirmed that monthly assessment of restraints was not being completed and also noted that annual evaluations of programs had not been completed in 2013

The licensee's Policy "Least Restraint Policy- physical restraints" RSL-SAF-035 describes a physical restraint;
Physical - Device used to inhibit freedom of physical movement and which cannot be removed by the resident on command. Types of permitted physical restraints include:
-safety belts (if resident unable to release buckle on command) used for the prevention of falls or injury that inhibit the normal freedom of movement or ambulation
-full or 3/4 side rails used for the prevention of falls or injury that inhibit normal

freedom of movement or ambulation
Prohibited devices that limit movement include:
-any device used to restrain a resident to a commode or toilet
PROCEDURE:
-The decision to apply a restraint will be made in consultation with the resident/POA, with informed consent given in writing. The resident /POA will be provided with a copy of the informed consent.
-A physician's order must be obtained prior to the application of the restraint
-The physician's order for the use of restraints will include: the type of restraint, purpose of use and frequency of use.
-The restraint must be applied by qualified staff as per manufacturer's specifications and hourly checks will be performed and documented, reflective of time of application, removal, re-application and the resident's response. Repositioning(full release of the restraint device and physical weight off loading and shifting) will occur every two hours at minimum. Registered staff will evaluate the continued use of restraints as well as the resident's response each shift at minimum, reflected in the restraint documentation record.
-The ongoing use of the restraint will be evaluated at least quarterly by registered staff, documented in the multidisciplinary progress notes, plan of care and RAPS and the initial and annual care conference notes.
(194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2014

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. 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 will ensure that required levels of lighting are provided in all areas of the long term care home including:

• A minimum level of 215.28 lux in all residents' bedrooms, tub and shower rooms.

The licensee will provide a written progress report to indicate the status of the lighting levels by November 1, 2014.

This progress report must be submitted in writing to the MOHLTC, Attention: Wendy Berry, Fax (613)569-9670.

Grounds / Motifs :

1. On April 30 and May 01, 2014 illumination levels in resident areas were checked by Inspector 102. A hand held GE light meter was used. The meter was held 3 to 4 feet above the floor surface with all available electric light fixtures turned on within each room. Window coverings were closed when light levels were measured in residents' bedrooms. Levels of illumination throughout 2nd and 3rd floor residents' bedrooms, which in some bedrooms also includes alcoves, ranged from less than 50% to 75% of the required lighting level of 215.28 lux throughout the majority of the bedroom. Lighting levels were compliant in close proximity to wall mounted lighted fixtures and underneath most ceiling light fixtures.

Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments; to conduct assessments; to provide treatments. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility and overall quality of life. (102)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (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:
-repairing, refinishing and/or replacing, as appropriate, all damaged floor surfaces
-repairing and/or replacing, as appropriate, all damaged window and door seals
-repairing and/or replacing, as appropriate, all damaged and or missing window coverings, light fixtures and bed rail covers.
-repairing and/or replacing, as appropriate, all damaged surface veneer on bedside tables, freestanding wardrobes and head/foot boards.

The licensee will provide a written plan indicate the by June 10, 2014.

This plan must be submitted in writing to the MOHLTC, Attention: Wendy Berry, Fax (613)569-9670.

Grounds / Motifs :

1. Furnishings and equipment are not maintained in a safe condition and a good state of repair:
-floor coverings were damaged in the 2nd floor central bathing area: shower floor ripped and lifting in 2 areas; ripped, peeling and soiled duct tape across the threshold strip across the doorway at the entrance to the bathing room. The textured floor surface within this bathing room was also visibly soiled. Non intact

floor coverings are a potential safety risk and can not be properly cleaned.
-the floor covering is lifting in the doorway leading into room 209's washroom which is a potential tripping hazard; a gap is evident at the floor wall juncture in room 218's washroom which is difficult to clean and prevent the build up of moisture and debris
-seams are lifting from floor coverings in the 2nd floor shower room and 2nd floor central bathing room exposing gaps in the floor surface
-windows seals are damaged as evidenced by moisture build up causing fogging and staining between window panes in several areas preventing residents from having a clear view to the outside: room 302 (1 window); 2nd floor common room (1 window); 3rd floor dining room (1 window); north end of 3rd floor corridor (1 window)
-during the inspection on April 30 and on May 01, 2014 water was observed leaking from the base of the sliding glass doors in the 2nd floor common room and from the top of the window frame in bedroom 211. In both areas water had pooled on the floor surface presenting a potential safety risk.
-window coverings were damaged and/or missing in the 2nd and 3rd floor common rooms that are also used for dining compromising resident comfort (raised by Residents' Council)
-in the 2nd and 3rd floor central bathing areas, hanger mounts for shower heads will not hold the shower heads in place
-some of the light fixtures, including moisture proof fixtures, are missing covers in the vicinity of bathing fixtures in 2nd and 3rd floor central bathing areas presenting a potential safety risk
-the finish around the side entry bath tub's drain is cracked and chipped in the 3rd floor bathing area across from room 323 presenting a potential cross infection risk
- a number of bed rail covers that were in use had non intact surfaces presenting a potential cross infection risk
-surface veneer was damaged on many bedside tables, free standing wardrobes, on some head boards and foot boards of beds and from desk and counter surfaces at the 2nd floor nurses station and the adjacent counter area. Non intact surfaces can not be adequately cleaned and disinfected as needed presenting a potential infection control risk. Damaged surfaces may also present a safety risk for residents with fragile skin.
- end caps are missing from corridor hand rails in a number of areas on the 2nd and 3rd floors.

Not maintaining the home, furnishings and equipment in a safe condition and a

good state of repair presents potential risks to the health, comfort, safety and well being of residents.
(102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2014

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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee will ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. That will include:
-immediate measures are taken to mitigate risks to residents where beds that are equipped with bed rails that have been evaluated and identified to have potential zones of entrapment and any other safety issues related to the use of bed rails according to Health Canada's guidance document titled " Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" are addressed, and
-a follow up assessment of the beds with bed rails is to be conducted by the licensee by June 15th, 2014 to ensure that identified entrapment zones and any other safety issues have been resolved.

Grounds / Motifs :

1. O. Reg. 79/10, s.15(1)(a) identifies that where bed rails are used, the resident is to be assessed and his or her bed system is to be evaluated in accordance with prevailing practices, to minimize risk to the resident.
Evidence based prevailing practices are identified in Health Canada's guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", effective date 2008/03/17.
During an inspection in the home by Inspector 102 on April 29, 30 and May 01, 2014 full length, chrome type bed rails with a potential zone of entrapment within the inner perimeter of the rails were identified to be in use on 8 residents' beds. Partial padded covers were in use on several of the identified bed rails; however, the covers did not fully cover potential entrapment zone openings. Residents were observed laying in a number of the identified beds with rails in the "up" position.
During the inspection, management staff of the home provided written documentation identifying that a bed system evaluation had been conducted on June 09, 2011. A copy of the 4 page report titled "Facility Entrapment Inspection Sheet" was provided to the inspector. The report identified more than 24 beds with entrapment zone failures. Staff of the home confirmed that adjustments were subsequently made to some of the beds and that a number of beds were replaced. Evidence of a follow up evaluation of the bed systems was not provided.
At the time of this inspection, all necessary steps had not been taken to minimize risk to residents taking into consideration all potential zones of entrapment, placing residents at risk of harm from entanglement in or around the bed rails. (102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 16, 2014

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 : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee shall ensure that policies are followed and practices reflect the implementation of the Infection prevention and control program including;
-Isolation measures as directed in the licensee's policy "General Control Measures" ICM-OBM-007
-Notification of the Public Health Unit related to surveillance lists as directed in the licensee's policy "Outbreak Management" ICM-OBM-005
-The use of Personal Protective Equipment (PPE) by staff for respiratory illness as directed in the licensee's policy "General Control Measures" ICM-OBM-007
-An annual evaluation of the Infection prevention and control program completed as required in O. Reg. 79/10 s. 229(2)(d)

Grounds / Motifs :

1. Review of the licensee's "Outbreak Management Surveillance" Policy " ICM-DUR-005 directs;
Clinical case definitions for respiratory tract outbreak:
-Two cases of acute respiratory tract illness occurring within 48 hours in a geographical area (eg unit, floor) or
-More than one unit having a case of acute respiratory illness within 48 hours
The policy defines Upper Respiratory Tract Illness(including common cold, pharyngitis)
-the resident must have at least 2 of the following (new) symptoms:
-runny nose or sneezing
-stuffy nose(ie congestion)
-sore throat or hoarseness or difficulty swallowing
-dry cough
-swollen or tender glands in the neck (cervical lymphadenopathy)
-fever/abnormal temperature for the resident may be present, but is not required
-for suspected influenza outbreaks you may also consider adding the following

symptoms: tiredness, malaise, muscle aches (myalgia) loss of appetite, headache, chills.
The licensee's policy "Elements of Surveillance" ICM-SUR-005 directs, the following in the event of a potential or confirmed outbreak
Notify the local Medical Officer of Health or Designate at your Health Unit of the Potential or confirmed Outbreak
-Provide the Medical Officer of Health or designate with an updated line listing.
Note: do not wait until the line listing is completed to notify the MOH.
Review of the home's line listing for the period of April 8 - April 25, 2014 was completed.
-April 17, 2014
-Resident # 16 is identified as having nasal congestion, hoarseness and a dry cough
-Resident # 4293 is identified (in the progress notes) as having a congested cough and an elevated temperature
April 20 2014
- Resident # 2 is identified as having hoarseness and a dry cough
-Resident # 16 is identified as having hoarseness, dry cough and a temperature
-Resident # 1 is identified as having hoarseness, dry cough, temperature and wheeze/rales
-Resident # 20 is identified as having hoarseness, dry cough and temperature
-Resident # 17 is identified as having hoarseness, dry cough
-Resident # 4243 is identified as having nasal congestion, sore throat, and hoarseness
April 22, 2014 two additional resident were identified in the line listing
-Resident # 5765 is identified as having nasal congestion, dry cough
-Resident # 4 is identified as having sore throat, hoarseness and a dry cough
Another Floor:
No line listing available for the period of April 20, 2014 to April 25, 2014
April 21, 2014
-Resident # 7132 is identified (in the progress notes) as having a hoarse voice, coughing, sneezing and complaints of a sore throat and generally not feeling well.

DOC confirmed that Medical Officer of Health or designate had not been notified of the potential outbreak and was not provided with the current line listing
(555)

2. During observation of tray service on April 22, 2014 Residents #1, 2, 3, 4,

4293, 4243 were seated and being served lunch on portable tables in the hallway. Interview with Staff #101 confirmed that residents were seated in the hallway related to being on isolation precautions and unable to be served lunch in main or unit dining room.
- Staff #102 was observed assisting to feed a resident in hallway with no PPE in place. Staff #102 confirmed that the resident was being served lunch in hallway related to being on droplet precautions. Staff #102 reported droplet precautions required PPE within 10 feet of the resident. When asked if her seated position was less than 10 feet from the resident the staff replied yes, then applied PPE and continued assisting resident with the meal.
- When residents are seated in hallway on droplet precautions for meals, it does not allow for the required 10 feet radius for others to pass.
- A co- resident was observed sitting on a walker talking with a resident seated at a portable table in the hallway(for droplet precautions) the co- resident on walker was not wearing PPE.
(555)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 06, 2014

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

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

and the Director

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

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

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

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 22nd day of May, 2014

Signature of Inspector / Signature de l'inspecteur : Chantal Lafreniere #194

Name of Inspector / Nom de l'inspecteur : Chantal Lafreniere

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