Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 3, 2014	2014_360111_0021	O-000364-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE COBOURG
130 NEW DENSMORE ROAD, COBOURG, ON, K9A-5W2

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

LYNDA BROWN (111), PATRICIA BELL (571), SUSAN DONNAN (531), 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): August 11-15 & 18-22, 2014

Three complaints were completed concurrently during this inspection (log#000212, 000697& 000640).

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care(DOC), Residents, Families, Resident Council President, Family Council President & Vice President, Environmental Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers(PSW), and Dietary Aides.

During the course of the inspection, the inspector(s) A complete tour of the home, observation of meal service, reviewed health care records of residents, reviewed minutes from resident council & family council, reviewed polices on restraints, medication administration, infection prevention and control, complaints, preventions of abuse and neglect, falls prevention, and reviewed staff health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
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 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; O. Reg. 363/11, s. 1 (1, 2).

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).

Findings/Faits saillants :

Resident accessible doors leading to non-secure areas outside of the long term care home are not equipped with an audible door alarm that allows calls to be cancelled only at the point of activation.

2. The resident accessible main entrance/exit door and the nearby resident accessible door that exits to the adjacent retirement home in the vicinity of the Administration offices, are not connected to the resident-staff communication and response system or to an audio visual enunciator that is connected to the nurses' station nearest to the

door.
3. The resident accessible main entrance /exit door and the nearby resident accessible door that exits to the adjacent retirement home in the vicinity of the Administration offices, are not kept closed and locked. Each of the identified doors is connected to a keypad that has been set up to simultaneously activate an automatic door opening device as well as a magnetic door lock release. The doors remain open and unlocked for approximately 45 to 50 seconds every time the code is input to enter or exit through the doors. Staff of the home identified that the keypad and door opening function were integrated a few years ago. The main entrance had previously been set up and equipped with a separate activator for the handicap door opener; an automatic opener was added to the separation door leading to the retirement home.

4. Eight resident accessible doors leading from corridors within the long term care home (LTC), to non secure areas outside of the home are not equipped with an audible door alarm that allows calls to be cancelled only at the point of activation:
- 2 exit doors to the outside in the Poplar House resident home area (RHA)
- 2 exit doors to the outside in the Pine House RHA
- 2 exit doors to the outside and 1 door leading outside of the LTC home into the adjoining retirement home in the Birch House RHA
- 1 exit door leading to the outside and 1 door leading outside of the LTC home into the adjoining retirement home in the vicinity of the main entrance and Administration offices.

5. Two resident accessible doors leading to non secure areas outside of the LTC home are not connected to the resident-staff communication and response system or to an audio visual enunciator that is connected to the nurses' station nearest to the door:
-1 exit door leading to the outside
-1 exit door leading outside of the LTC home into the adjoining retirement home in the vicinity of the main entrance and Administration offices.

6. One resident accessible door leading to a non secure area outside of the LTC home is not connected to the pagers, which is an integral component of the resident staff communication and response system in use in the home:
- the door leading from the Birch House RHA corridor into the adjoining retirement home, which is outside of the LTC home. The door does display on the visual display marquis that is located near the dining room in the RHA.

Resident safety and well being is potentially compromised when resident accessible doors are not equipped with audible door alarms that are connected to a fully functioning resident staff communication and response system or to an audio visual enunciator at the nurses' station nearest to each door. Residents are at increased risk of exiting the home without being detected. [s. 9. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

On August 14, 15 and 19, 2014 the illumination levels in Resident Home Areas(RHA) were checked by Inspector#102. A hand held GE light meter was used. The meter was held at varying heights above the floor surface. All available electric light fixtures were turned on and warmed up.

Levels of illumination throughout the Birch House, Poplar House and Pine House open concept program/lounge areas were less than 25% to 50% of the required lighting level of 215.28 lux throughout the majority of the rooms. Each room was lit by a track light with 3 movable spot light fixtures as well as 2 wall sconces on one wall.

The levels of illumination provided in the corridors throughout the Birch, Poplar & Pine House RHA were identified to range from less than 50 % to 75% of the required illumination level between many of the light fixtures, to greater than 215.28 lux directly under and in close proximity to the light fixtures. Shadowing was evident throughout RHA corridors. The corridors are illuminated by a combination of recessed pot light fixtures equipped with compact florescent bulbs and alcove lighting at bedroom doorways. A minimum level of 215.28 lux of continuous, consistent lighting is not provided throughout corridors.

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, nutritional intake, 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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The resident staff communication and response system provided and in use in the long term care home does not use sound to alert staff when a call for assistance is activated on the system. Pagers are an integral system component in Extendicare Cobourg and are intended to identify to nursing staff where an activated signal is coming from.

During the inspection which commenced on August 11, 2014 call system pagers were identified by nursing staff as missing, malfunctioning and/or broken. On August 14, 2014, the Administrator identified that 4 pagers had been determined to be operational and were distributed to PSW staff as follows: 2 pagers to staff in the Pine House; 1 pager to staff in Poplar House; 1 pager to the PSW who works in both the Pine and Poplar House. No pagers were allocated to staff of the Birch House.

A visual display "marquis" is provided as a component of the resident staff communication and response system in each RHA. It was identified that 3 resident accessible doors leading to non-secure areas outside of the Long-Term Care home did not alert on the resident staff communication and response system pagers or on the visual display "marquis".

It was identified during the inspection that the lounge and the dining room in Birch House did not alert to pagers that had been provided for staff use in the Birch House

on August 19, 2014. It was also identified by Inspector#102 that the alert initiated from the system's activator station in the lounge was identified as "436" on the visual display "marquis", which is the same identifier as one resident bedroom that is located in close proximity to the lounge.

Resident staff communication and response system monitoring records were requested by Inspector#02 and were provided by the Administrator. The "Tacera Call History" records covered the period from July 1, 2014 06:30 am to August 14, 2014 06:30 am. Responses to active calls that exceed 5 minutes were identified. The call monitoring history identified:
- Poplar House: 141 calls activated on the system that took more than 10 minutes to either respond to or to cancel at the point of activation; 20 of the identified active calls were between 20 and 58 minutes to cancel.
-Pine House: 194 calls activated on the system took more than 10 minutes to respond to or cancel at the point of activation; 60 of the identified calls took between 20 and 60 minutes to cancel.

The resident staff communication and response system does not clearly indicate when activated where the signal is coming from which is a risk to the health, comfort, safety and well being of residents.

On August 19, 2014, the Administrator reported that additional pagers had been obtained and provided to nursing staff in each RHA. [s. 17. (1) (f)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee failed to ensure that the written plan of care provided clear directions to staff and others who provide direct care to the resident related to skin care.

Observation of Resident #33 on specified dates indicated the resident had an alteration in skin integrity to a specified area. Two days later, the same area was observed covered with an non-adherent dressing.

Interview of the RPN #105 indicated the dry dressing was not applied by the staff member and unable to determine who applied the dressing.RPN#105 indicated the dressing is applied as needed.

Review of the care plan(current) for Resident #33 indicated under skin integrity the resident has an area of impairment to a specified location and one intervention which included application of ointment as prescribed.Review of the physician orders and the treatment administration records (TAR) only indicated the application of ointment.

Therefore, there was no clear direction to staff who provide direct care to the resident when and why a dressing is applied to the resident's alteration in skin integrity.[s.6(1)(c)]

2. Related to log #000640:

The licensee failed to ensure that the written plan of care provided clear directions to staff and others who provide direct care to the resident related to risk of skin injury.

Review of the progress notes of Resident #25 indicated on three different dates, the resident sustained a tissue injury. Two of the dates had an unknown cause and one of the dates was related to responsive behaviours.

Review of care plan for Resident #25 indicated under skin integrity, the resident has potential for skin breakdown but no indication the resident was at risk for skin injury or interventions to reduce the risk of injury. [s.6(1)(c)]

3. The licensee failed to ensure that the written plan of care provided clear directions to staff and others who provide direct care to the resident related to oral hygiene.

Interview of Resident #36 indicated that staff does not provide assistance with oral hygiene in the morning and the resident's family provides assistance with oral hygiene in the evening.

Interview of PSW #116 was unaware Resident #36 had dentures and required assistance with oral hygiene.

Review of the current Care Plan for Resident #36 under oral care, indicated the

resident required extensive assistance with part of hygiene but resident can participate and assist with brushing teeth There was no indication of dentures. [s.6(1)(c)]

4. The licensee failed to ensure the resident received care as indicated in the plan related to eating.

On August 11, 2014 an observation of the dining service during lunch in one home area was conducted:
-Resident #17 was observed not consuming any of the lunch meal. Staff #113 only intervened an hour later when Inspector#571 had inquired whether Resident #17 required assistance. Staff #113 & Staff #112 provided assistance and encouragement with eating and the resident consumed 1/2 of the lunch meal.
-After the lunch service, Staff #112 was observed giving Resident #17 a desert and then walked away from the resident. Resident #17 then dropped the desert to the floor. Staff #112 then returned to the resident and offered the resident a fruit instead but the resident declined.

Review of Resident #17's plan of care related to eating indicated the resident was cognitively impaired, and required cuing, supervising and encouragement at meals. The licensee failed to ensure that Resident #17 received the assistance based on the resident's needs as indicated in plan of care. [s.6.(7)]

5. Related to log# 000212:

The licensee failed to ensure the plan of care was reviewed and revised when the resident's care needs changed related to nutritional and hydration status.

Review of the care plan for Resident #42 indicated the resident required total assistance of one staff with eating due to cognitive impairment and ate in the main dining room. The resident was a high nutritional risk (due to nutritional priority screen assessment). The resident was to be weighed monthly, on a regular, no salt diet with pureed texture, and honey thick fluids. The resident was to receive a routine nutritional supplement and to receive an additional nutritional supplement if the resident refused a meal.

Interview of RPN#101 indicated that all supplements administered are recorded on the Medication Administration Records(MARS), including PRN supplements.Interview of

PSW# 104 indicated that supplements given are recorded on the "daily food and fluid intake".

Review of Resident#42 "daily food and fluid intake" for a specified month indicated there was 10 days when the resident had refused/sleeping for all of the nourishment's. The resident had only been consuming approximately 25-50% of breakfast and lunch meals, and had been consuming 50-100% of supper meals. The resident was also consuming approximately 7 servings(4 oz of fluids daily). Over a two day period, the resident was "sleeping" through all meals, fluids and nourishment's. There was no documented evidence the resident received any as needed (PRN) supplements during that month.

Review of the MAR during the same month indicated the resident had a nutritional supplement that was to be given PRN if resident refused a meal. There was no documented evidence the resident received the PRN supplement during that month despite sleeping/refusing several meals.

Review of the progress notes for Resident #42 related to nutritional status indicated:
-during a specified month, the resident was assessed by the Dietary Manager who indicated the resident was eating all meals and nourishments, and consuming adequate fluids. The resident was receiving a routine nutritional supplement for weight maintenance, and weight was stable.
-the following month, the resident had a change in condition and the resident's appetite decreased for a 10 day period. The resident had not consumed any food or fluids for 3 consecutive days after that. The resident had abnormal blood work which resulted in the resident being transferred to hospital for assessment. The resident returned from hospital 5 days later with a dietary referral and 6 days after that, a dietary referral was completed.

There was no indication the plan of care was reviewed and revised when the resident's care needs changed until 6 days after the resident returned from hospital, despite the resident having had decreased intake of food and fluids. [s.6.(10)(b)]

6. The licensee failed to ensure that the plan of care was reviewed and revised when the care needs changed related to the use of a restraint.

Observation of Resident #32 indicated the resident spent most of the day in a restraining mobility aid and with a trunk restraint in place. The resident is cognitively

impaired and was unable to remove the restraint.

Review of the care plan for Resident #32 under physical restraints indicated the use of a restraining mobility aid, use of alerting device and not to use a trunk restraint due to risk of injury from responsive behaviours.

Review of Doctor's order indicated a trunk restraint was ordered. There was no indication of a restraining mobility aid ordered.

Interview with Staff #102, #120 and #119 indicated that Resident#32 no longer demonstrated responsive behaviours that posed a risk of injury with the use of the trunk restraint.Staff #120 indicated the physician was contacted to clarify the restraint order/risk but the trunk restraint order was to continue.(571)

7. Related to Log # 000212:

The licensee failed to ensure the plan of care was reviewed and revised when the resident's care needs changed related to falls risk.

Review of the progress notes for Resident #42 indicated during a 5 month period, the resident sustained 5 falls. The resident was assess by physiotherapy twice during that period. The first assessment recommended monitoring/repositioning when in the mobility aid. The second assessment had no recommendations . Seven days after the second physio assessment, a referral was made to physio regarding an unsafe device on the resident's mobility aid. The assessment by physio was not completed for approximately one month. After the 4th fall, the resident's mobility aid was changed, an alarming device and restraint was put in place. The resident's last fall occurred from a mechanical lift resulting in an injury requiring transfer to hospital. The resident's condition then deteriorated and died approximately one month later.

Review of post-fall assessments for Resident #42 indicated:
-no post-fall assessment was completed for the first fall.
-post-fall assessment completed for the second fall indicated the resident was a high risk for falls and "care plan not requiring update".
-post-fall assessment completed for the third fall had no recommendations and "care plan not updated".
-post-fall assessment completed for the fourth fall recommended an alarming device, referral to physio and trunk restraint when in the mobility aid.

Review of the care plan (in place during that time period) indicated:
-nursing indicated the resident was a "high risk" for falls due to a history of falls.
-physio indicated the resident was a "moderate risk" for falls.

Therefore, there was no indication the resident's care plan was based on the assessed needs of the resident, as: the resident continued to fall from a mobility aid, interventions were not revised until after the resident sustained 4 falls, and the care plan was not revised until the resident sustained a serious injury from mechanical lift. [s.6(10)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that written plan of care related to skin care and oral hygiene for resident`s provides clear directions to staff and others, to ensure residents receive care based on the assessed needs of the resident related to falls risk, bathing, skin care, and restraint use, the plan of care is provided to residents related to eating, and the plan of care is reviewed and revised when the residents care needs change related to nutrition and hydration, to be implemented voluntarily.

WN #5: 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 :

Related to log #000212:

Under O.Reg. 79/10, s. 68(2) Every licensee of a long-term care home shall ensure that the programs include, (a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; (b) the identification of any risk related to nutrition care and dietary services and hydration.

Review of the homes policy "Food and Fluid Intake Monitoring" (RESI-05-02-05) revised November 2013 indicated:
-Care staff are to document resident food and fluid intake after meals, snacks and nourishment's including any special items and nutritional supplements and report any concerns regarding resident's food or fluid intake to the Registered Staff including refusals.
-Registered Staff are to review resident food and fluid intake records daily. If a resident does not consume minimum fluid target levels assessed by the Registered Dietitian/registered staff designate for three consecutive days, a dehydration assessment must take place.
-A referral to the Registered Dietitian also needs to be sent if the resident leaves 25% or more of foods for 2 out of 3 meals over a seven day period or, refuses to eat for 3 or more consecutive meals.

Review of Resident#42 "daily food and fluid intake" for a specified month indicated there was 10 days when the resident had refused/sleeping for all of the nourishment's. The resident had only been consuming approximately 25-50% of breakfast and lunch meals, and had been consuming 50-100% of supper meals. The resident was also consuming approximately 7 servings(4 oz of fluids daily). Over a two day period, the resident was "sleeping" through all meals, fluids and nourishment's. There was no documented evidence the resident received any as needed (PRN) supplements during that month.

Review of the progress notes for Resident #42 related to nutritional status indicated:
-during a specified month, the resident was assessed by the Dietary Manager who indicated the resident was eating all meals and nourishments, and consuming adequate fluids. The resident was receiving a routine nutritional supplement for weight maintenance, and weight was stable.
-the following month, the resident had a change in condition and the resident's appetite decreased for a 10 day period. The resident had not consumed any food or

fluids for 3 consecutive days after that. The resident had abnormal blood work which resulted in the resident being transferred to hospital for assessment. The resident returned from hospital 5 days later and 6 days after that, a dietary referral was completed.

There was no indication the care staff had reported concerns of decreased consumption of food and fluids and frequent meal refusals, no indication the registered staff completed a dietary referral related to decreased food and fluid intake until after the resident returned from hospital, and no indication a hydration assessment was completed when the resident had not consumed any food or fluids in 3 consecutive days.[s.8(1)(a),s.8(1)(b)]

2. Under LTCHA, 2007, c. 8, 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 (b) shall ensure that the policy is complied with.

Review of the homes policy "Physical Restraints" (November 2012), states that care staff are to ensure the "Restraint Record" is completed. Monitoring of restraint use must be completed with hourly safety checks and two hourly position changes which requires documentation.

Observation of Resident #12, over a 3 day period, at various times during the day, the resident was observed wearing a trunk restraint.

Review of the clinical record for Resident #12, indicated there was no documented evidence of a "Restraint monitoring record" in use for a two month period. The clinical record also indicated that the trunk restraint had been discontinued by the physician approximately 2 months prior.

Therefore, the licensee failed to ensure the the homes policy was complied with as a resident who was using a trunk restraint was not monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff using the restraint monitoring record. [s. 8. (1) (a),s. 8. (1) (b)]

3. Related to log #000640:

Under O.Reg.79/10, s.132. (1) Every licensee of a long-term care home shall ensure that where a resident wishes to use a drug that is a natural health product and that has not been prescribed, there are written policies and procedures to govern the use, administration and storage of the natural health product. O. Reg. 79/10, s. 132 (1).

Review of the homes policy "Administration of Natural Health Products" (3-10) indicated:
-natural health products not labelled with a Natural product number or drug identification number may only be taken with authorization of the physician.
-nursing staff only administer natural health products that have been prescribed by a physician
-family administered medications must be stored in a secure area, inaccessible to other residents.

Observation of Resident#25 room by Inspector #531 noted that there were three unsecured containers of a natural health product that were provided by the family. Each container had different locations on where the product was to be used on the resident. None of the containers had an identification number.

Interview of RPN #101 by Inspector #531 indicated that the family member of Resident #25 had initially supplied only the one container of the natural health product and it was to be applied to a specific location only. RPN#101 indicated the family member was applying the same natural health product to another location on the resident. RPN #101 indicated the family member also instructed staff to apply the natural health product to a different location from the same container. RPN #101 indicated the family member did not supply the two other containers until approximately 2 months later after a care conference that occurred requesting additional containers.

Review of physician orders indicated the natural health product was to be used twice daily to one specified location and family will supply. That order was placed on hold and a new order for antibiotics was received after the resident developed an infection to the new location that the natural health product was being applied to.

Therefore, the licensee failed to ensure the application of a natural health product (which did not have an identification number) was kept in a secure location, and was only used according to the direction of the physician as the application of the natural health product was applied to an area that was not prescribed by the physician and

was provided from the same container (which posed risk of cross contamination). [s.8(1)(b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the licensee policies of Food and Fluid Intake Monitoring, Drug Destruction and Disposal, Physical Restraints, and Administration of Natural Health Products, are complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

Related to log# 000640:

The licensee has failed to ensure that an alleged incident of improper care that was reported to the licensee, was immediately investigated.

Interview of the Administrator & DOC on August 22, 2014 indicated the DOC received a written complaint (dated June 30, 2014) on July 2, 2014 from a family member for

Resident #25. The Administrator indicated she contacted the family member on July 2, 2014 to clarify the nature of the complaint and notified of an alleged improper care from PSW#103 towards Resident #25. The Administrator indicated a call was also received from the physician indicating that the family member and POA of Resident #25 had reported the allegation to the police. The Administrator indicated a critical incident report was submitted to the Ministry on July 2, 2014 regarding the allegation. The Administrator was not able to provide a documented investigation at that time and replied "I forgot to complete it". The Administrator indicated PSW #103 was contacted regarding the allegation on July 6, 2014. When the Administrator was asked why she waited until July 6, 2014 to contact PSW#103, indicated "the PSW was off until then". The Administrator indicated the critical incident report submitted on July 2, 2014 had not not yet been amended with the outcome of the homes investigation. The Administrator indicated the investigation was concluded on August 13, 2014 and the complainant was notified of the outcome during a care conference was held on August 13, 2014. The DOC later provided an copy of the homes written investigation (at 14:30 hrs) that was dated August 22, 2014.

Review of the nursing staff schedule indicated PSW #103 was working the same day the written complaint was received and was working during three of the four days after the written complaint of improper care was received.

Review of the health record for Resident #25 indicated the complainant is a family member but not the POA. Review of the progress notes for Resident #25 indicated:
-on June 25, 2014 the DOC indicated the family member came in and reported concerns regarding the resident's change in skin condition to a specified area as a result of improper care.
-on June 29, 2014 the family member returned to the home and was very angry regarding the resident's skin condition and again alleged improper care.
-on July 2, 2014 the physician contacted the RPN indicating "I just wanted to give you the heads up that [the family member] has called the police and the ministry about [improper care]". This was reported to the DOC and Administrator.

There was no indication when the licensee received a verbal complaint of alleged improper care on June 25 & 29, 2014, that an investigation was initiated until July 6, 2014, 12 days later. A documented investigation into the allegation of staff to resident improper care was not completed until August 22, 2014 as a result of the inspection. [s.23(1)(a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee immediately investigates, responds and acts to every alleged, suspected, or witnessed incidents of improper care of a resident by a staff, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

Related to log# 000640:

The licensee has failed to ensure that when the DOC and Administration had reasonable grounds to suspect alleged improper or incompetent treatment of a resident that resulted in harm, it was immediately reported to the Director.

The licensee received a verbal complaint from the family member of Resident #25 on two specified dates alleging the resident received improper care. The Administrator confirmed that the Director was not notified of the alleged improper care of resident #25 until 9 days later when the critical incident report was submitted.[s.24(1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the licensee has reasonable grounds to suspect improper care or incompetent treatment of a resident that resulted in harm or risk of harm, is immediately reported to the Directors, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee failed to ensure that Resident #36 & #40 was bathed at a minimum twice weekly as requested, by the method of their choice. [s.33(1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are bathed at a minimum twice weekly by the method of his or her choice, to be implemented voluntarily.

WN #9: 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 :

During the inspection on August 14, 15, 18 and 19, 2014 inspector #102 observed plastic type lip plates stacked and available for use within serveries in all 3 resident home areas. It was confirmed that the plates are used during meal services.

A number of the plates in use were observed to have non intact, worn and peeling surfaces. Some of the plates were visibly discolored on the food contact surfaces.

Non intact food contact surfaces can not be effectively cleaned and sanitized. The plates are not maintained in safe condition and a good state of repair. [s.15(2)(c)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

The licensee failed to ensure that Resident #32 was weighed monthly.

A review of the clinical record for Resident #32 indicated during a 6 month period the resident had been weighed 3 times. The last weight obtained indicated an 18% weight loss.

In an interview RN #114 indicated the practice is for the PSW's to record the weights of all residents on the weight chart within the first 7 days of the month. If they are unable to obtain weight then the PSW will try several times. RN #114 indicated that it is not difficult for staff to obtain a monthly weight for Resident #32.[s.68(2)(e)(i)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

The licensee failed to ensure that residents with weight changes of 5 % of body weight, or more over one month are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

A review of the clinical record for Resident #17 indicated the resident had an 8% weight loss over a two month period. There was no documented evidence of a referral to the Dietician by a registered staff member despite the 8% weight loss. A quarterly review by the Dietician was completed during this period but did not refer to the 8% weight loss or any actions to be taken. [s.69,1.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

The licensee failed to ensure that where a resident is being restrained by a physical device, the staff only apply the physical device that has been ordered or approved by a physician or Registered Nurse in the extended class.

Observation of Resident #12, on three specified dates, at various times during the day, indicated the resident was cognitively impaired, and observed wearing a trunk restraint while in a mobility aid that the resident was unable to remove.

A review of the clinical record indicated that approximately 2 months prior, the trunk restraint was discontinued by the physician.[s.110(2)1.]

WN #13: 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. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

s. 136. (5) The licensee shall ensure,
(a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective; O. Reg. 79/10, s. 136 (5).
(b) that any changes identified in the audit are implemented; and O. Reg. 79/10, s. 136 (5).
(c) that a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 136 (5).

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 :

The licensee has failed to ensure that when a drug that is to be destroyed, and is not a controlled substance, is destroyed by a team acting together and composed of one member of the registered nursing staff and one other staff member appointed by the Director of Nursing and Personal Care.

On August 18th, 2014 interview of Staff #100, #110, #111 confirmed that non-controlled medications for destruction are placed in a small cardboard box and the Director of Care removes the box and stores them in a locked room and arranges for the contracted medical waste company for pick up and disposal.

On August 18th, 2014 the Director of Care confirmed that the non-controlled drugs for destruction are not destroyed by a team acting together. [s.136(3)(b)]

2. The licensee has failed to ensure the drug destruction system has been audited to verify that the licensee's procedures are being followed.

On August 21, 2014 the Director of Care confirmed that the drug destruction and disposal system has not been audited and there is no written record to support an audit has been completed. [s.136(5)]

3. The licensee has failed to ensure that non-controlled drugs to be destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

On August 18th, 2014 the Director of Care was interviewed and confirmed that the non-controlled drugs are placed in a box lined with a yellow hazardous plastic bag that is sealed and removed by the contracted bio-hazardous waste without denaturing. [s.136(6)]

WN #14: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

The licensee has failed to ensure that all staff participate in the implementation of the infection control program in the handling of supplies.

The following observations were noted by the inspector on August 12, 18 & 19th, 2014:
- unwrapped toilet paper on the toilet tanks in 4 resident bathrooms.

On August 19th, 2014 Inspector #111 observed unwrapped toilet paper rolls on the back of the toilet tanks in 3 different resident bathrooms. One of the bathrooms had a broken toilet paper dispenser.[s.229(4)]

2. The licensee has failed to ensure each resident admitted to the home was screened for tuberculosis within 14 days of admission.

Review of Resident #41 immunization record confirmed the resident was admitted to the home on a specified date and the resident was not screened for tuberculosis 35 days post admission. [s.229(10)1.]

3. The licensee has failed to ensure residents were offered immunizations against tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Review of immunization record for Resident #39, #40, and #41 had no documented evidence the residents were offered tetanus and diptheria immunization.

Interview of the DOC confirmed that residents were not offered tetanus and diptheria but "they are working toward this". [s.229(10)3.]

Issued on this 17th day of September, 2014

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

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) :	LYNDA BROWN (111), PATRICIA BELL (571), SUSAN DONNAN (531), WENDY BERRY (102)
Inspection No. / No de l'inspection :	2014_360111_0021
Log No. / Registre no:	O-000364-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 3, 2014
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE COBOURG 130 NEW DENSMORE ROAD, COBOURG, ON, K9A-5W2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LYNDA DAVLUT

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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.

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.

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.

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).

Order / Ordre :

The licensee will ensure that all resident accessible doors leading to non-secure areas outside of the long term care home:
1. are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
2. are connected to:
-the resident staff communication and response system, or
-an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

Grounds / Motifs :

1. 1.Resident accessible doors leading to non-secure areas outside of the long term care home are not equipped with an audible door alarm that allows calls to be cancelled only at the point of activation.

2. The resident accessible main entrance/exit door and the nearby resident accessible door that exits to the adjacent retirement home in the vicinity of the Administration offices, are not connected to the resident-staff communication and response system or to an audio visual enunciator that is connected to the nurses' station nearest to the door.

3. The resident accessible main entrance /exit door and the nearby resident accessible door that exits to the adjacent retirement home in the vicinity of the Administration offices, are not kept closed and locked. Each of the identified doors is connected to a keypad that has been set up to simultaneously activate an automatic door opening device as well as a magnetic door lock release. The doors remain open and unlocked for approximately 45 to 50 seconds every time the code is input to enter or exit through the doors. Staff of the home identified that the keypad and door opening function were integrated a few years ago. The main entrance had previously been set up and equipped with a separate activator for the handicap door opener; an automatic opener was added to the separation door leading to the retirement home.

4. Eight resident accessible doors leading from corridors within the long term care home (LTC), to non secure areas outside of the home are not equipped with an audible door alarm that allows calls to be cancelled only at the point of activation:
- 2 exit doors to the outside in the Poplar House resident home area (RHA)
- 2 exit doors to the outside in the Pine House RHA
- 2 exit doors to the outside and 1 door leading outside of the LTC home into the

adjoining retirement home in the Birch House RHA
- 1 exit door leading to the outside and 1 door leading outside of the LTC home into the adjoining retirement home in the vicinity of the main entrance and Administration offices.

5. Two resident accessible doors leading to non secure areas outside of the LTC home are not connected to the resident-staff communication and response system or to an audio visual enunciator that is connected to the nurses' station nearest to the door:
-1 exit door leading to the outside
-1 exit door leading outside of the LTC home into the adjoining retirement home in the vicinity of the main entrance and Administration offices.

6. One resident accessible door leading to a non secure area outside of the LTC home is not connected to the pagers, which is an integral component of the resident staff communication and response system in use in the home:
- the door leading from the Birch House RHA corridor into the adjoining retirement home, which is outside of the LTC home. The door does display on the visual display marquis that is located near the dining room in the RHA.

Resident safety and well being is potentially compromised when resident accessible doors are not equipped with audible door alarms that are connected to a fully functioning resident staff communication and response system or to an audio visual enunciator at the nurses' station nearest to each door. Residents are at increased risk of exiting the home without being detected. (102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 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 of 215.28 lux of continuous consistent lighting in corridors;
• A minimum level of 215.28 lux in the program/lounge space in each Resident Home Area.

The licensee will provide a written progress report by February 15, 2015, indicating the status of action taken or planned to rectify lighting levels. This progress report must be submitted in writing to the MOHLTC, Attention: Wendy Berry, Fax (613)569-9670.

Grounds / Motifs :

1. On August 14, 15 and 19, 2014 the illumination levels in Resident Home Areas(RHA) were checked by Inspector#102. A hand held GE light meter was used. The meter was held at varying heights above the floor surface. All available electric light fixtures were turned on and warmed up.

Levels of illumination throughout the Birch House, Poplar House and Pine House open concept program/lounge areas were less than 25% to 50% of the required lighting level of 215.28 lux throughout the majority of the rooms. Each room was lit by a track light with 3 movable spot light fixtures as well as 2 wall sconces on one wall.

The levels of illumination provided in the corridors throughout the Birch, Poplar & Pine House RHA were identified to range from less than 50 % to 75% of the required illumination level between many of the light fixtures, to greater than 215.28 lux directly under and in close proximity to the light fixtures. Shadowing was evident throughout RHA corridors. The corridors are illuminated by a combination of recessed pot light fixtures equipped with compact florescent bulbs and alcove lighting at bedroom doorways. A minimum level of 215.28 lux of continuous, consistent lighting is not provided throughout corridors.

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, nutritional intake, and overall quality of life. (102)

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee will ensure that the resident-staff communication and response system clearly indicates when activated, where the signal is coming from:
- A sufficient supply of operational pagers are to be provided for use by nursing staff in each resident home area;
- Operational pagers are to be carried by the staff who are assigned to initially respond to signals that are activated on the system
- The system and pagers are to be programmed to clearly identify where the activated signal is coming from, which in Extendicare Cobourg, also includes alerts for resident accessible doors that lead to non-secure areas outside of the long term care home.
Strategies are to be put in place to ensure that all components of the system, including the pagers and alerts for doors, are monitored for ongoing and sustained operation, function, availability and compliance.

The licensee is to prepare and submit a written plan of action identifying actions implemented to achieve and sustain compliance. The plan is to be submitted by fax by the date of September 15, 2014. The plan is to be faxed to Carole Comeau, Manager Ottawa Service Area office, Fax # 613 569 9670.

Grounds / Motifs :

1. The resident staff communication and response system provided and in use in the long term care home does not use sound to alert staff when a call for assistance is activated on the system. Pagers are an integral system component in Extendicare Cobourg and are intended to identify to nursing staff where an activated signal is coming from.

During the inspection which commenced on August 11, 2014 call system pagers were identified by nursing staff as missing, malfunctioning and/or broken. On August 14, 2014, the Administrator identified that 4 pagers had been determined to be operational and were distributed to PSW staff as follows: 2 pagers to staff in the Pine House; 1 pager to staff in Poplar House; 1 pager to the PSW who works in both the Pine and Poplar House. No pagers were allocated to staff of the Birch House.

A visual display "marquis" is provided as a component of the resident staff communication and response system in each RHA. It was identified that 3 resident accessible doors leading to non-secure areas outside of the Long-Term Care home did not alert on the resident staff communication and response system pagers or on the visual display "marquis".

It was identified during the inspection that the lounge and the dining room in Birch House did not alert to pagers that had been provided for staff use in the Birch House on August 19, 2014. It was also identified by Inspector#102 that the alert initiated from the system's activator station in the lounge was identified as "436" on the visual display "marquis", which is the same identifier as one resident bedroom that is located in close proximity to the lounge.

Resident staff communication and response system monitoring records were requested by Inspector#02 and were provided by the Administrator. The "Tacera Call History" records covered the period from July 1, 2014 06:30 am to August 14, 2014 06:30 am. Responses to active calls that exceed 5 minutes were identified. The call monitoring history identified:
- Poplar House: 141 calls activated on the system that took more than 10 minutes to either respond to or to cancel at the point of activation; 20 of the identified active calls were between 20 and 58 minutes to cancel.
-Pine House: 194 calls activated on the system took more than 10 minutes to respond to or cancel at the point of activation; 60 of the identified calls took between 20 and 60 minutes to cancel.

The resident staff communication and response system does not clearly indicate when activated where the signal is coming from which is a risk to the health, comfort, safety and well being of residents.

On August 19, 2014, the Administrator reported that additional pagers had been obtained and provided to nursing staff in each RHA. (102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 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 and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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