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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 24, 2015	2015_195166_0022	O-002682-15	Resident Quality Inspection

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East WHITBY ON L1N 6A3

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

FAIRVIEW LODGE
632 DUNDAS STREET WEST P.O. BOX 300 WHITBY ON L1N 5S3

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

CAROLINE TOMPKINS (166), JULIET MANDERSON-GRAY (607), KARYN WOOD (601), PATRICIA MATA (571)

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): September 8, 9, 10, 11, 14, 15, 16, 17, 18, October 20, 21 , November 6, 2015.

Complaint log O-002573-15 and Critical Incident logs, O-001024-14, O-001079-14, O-002496-15, O-002576-15, O-002615-15 and O-002750-15 were inspected concurrently with this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Representatives from the Resident and the Family Councils, Dietary, Housekeeping and Environmental staff, Resident Care Coordinators(RCC), Dietitian, Program staff, Physiotherapist,Occupational Therapist, Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), RAI Coordinators, Director of Food Services, Administrator, Assistant Administrator, Director of Care, Manager of Nursing Practice, Family/Resident Council Assistant, Receptionist and the Administrative Assistant.
During the inspection, the inspectors observed staff to resident interactions and resident to resident interactions, toured resident and non resident areas. The inspectors observed a noon and breakfast meal service, medication administration, resident programs and infection control practices.
The inspectors reviewed clinical health records, the licensee's investigation documentation and policies related to Infection Prevention and Control, Prevention, Reporting and Investigation of Abuse and Neglect, Falls Prevention and Management Program, Significant Unplanned Weight Loss, Continence Care and Bowel Management Program, Lift and Transfer Policy, Medication Administration Program, Plan of Care, Staffing Plan and Responsive Behaviour Prevention and Management Program.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **8 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are: equipped with locks to restrict unsupervised access to those areas by residents and locked when they are not being supervised by staff.

On September 8, 2105, the inside receiving doors, which are located in the corridor by the temporary main entrance and the workshop doors across from the elevator were observed to be propped open, there was no staff in these areas.
Inspector #571 entered the area without restriction. These non residential areas, contain tools , chemicals and industrial items.

On September 8, 2015, during the initial tour of the Cullen Gardens home area, Inspector# 601 observed door #1E33, within the servery was not locked.
This door leads to an area with a dishwasher, liquid dish detergent, chemicals, including peroxide, multi surface cleaner, oasis 146 multi quart liquid sanitizer, oasis 115 XP extra strength floor cleaner concentrate. The dishwasher area has another door that was also unlocked , this door leads to a service corridor that has an elevator, garbage and laundry chute.

On September 9 and September 10, 2015, at approximately 1500 hours on both days, Cullen Gardens, door #1E33 was again observed to unlocked. There was no staff in the service area at the time of the observation.

On September 8, 2015 at approximately 1030 hours and September 10, 2015, at approximately 0840 hours, the door to a non resident area, the staff utility corridor, on the Trafalgar Square home area, was found to be unlocked. This utility corridor contains the housekeeping cart and housekeeping supplies, including cleaning chemicals.

On September 10, 2015 at approximately 1530 hours, Inspector #571 observed the door to the Great Room to be unlocked and unoccupied. This room remains under construction and contains saws, scaffolding and other building supplies.

On September 11, 2015 at approximately 1555 hours, the door to kitchen service area, on the ground floor was observed to be propped open, Inspector #571 was able to access the non residential area, unrestricted.

On September 10, 2015, it was observed that the centre stairway doors , on all three floors were able to be opened without the use of a card reader. Above the doors that entrance each floor, there is a motion sensor that unlocks the door from the stair side, as

someone passes in the stairwell. Therefore allowing entrance to the stairs to become unlocked.

The staff washrooms in every resident home area are not locked, therefore allowing residents to access the washrooms, which do not have calls bell accessibility.
These unlocked doors to unsupervised nonresidential areas are a potential risk to the safety of the residents [s.9.(1)2.]

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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any equipment, supplies, devices, assistive aids, or positioning aids used by the staff are appropriate for the resident and based on the resident's condition.

Review of clinical documentation indicated that on an identified date and time, Personal Support staff alerted the Registered Nurse that Resident #40 was found with the lower body on the mattress and head on the floor mat.
The resident was assessed by the Registered Nurse and no injuries were noted at the time of the incident.
Post fall assessment indicated that the resident was last seen asleep, one half hour before the incident.
The assessment indicated two fall mats were in place on either side of the bed, the bed was in the lowest position to the floor, there were no bed rails on the bed.
The motion sensor alarms at the foot of the bed were turned on, but neither sensors were alarming.

On a specified date and time a second incident occurred.
Resident #40 was found positioned across the bed, torso on the floor mat and pelvic area on the bed.
The Registered Nurse assessed the resident and no injuries were found at the time of the incident.

Post fall assessment indicated, that the resident was seen asleep in bed, one half hour before the incident.
The assessment indicated, the bed was in the lowest position to the floor, the floor mats were on either side of the bed, there were no bed rails on the bed.
The motion sensor alarms at the foot of the bed were turned on but neither sensors were alarming.

The Resident's plan of care related to falls directs staff to :
-Observe resident hourly or more frequently for safety
-Bed in lowest position with 2 floor mats in place beside the bed and 2 sensors on the foot board to be operational.
-No bed rails
-Assess for causes of restlessness, i.e.pain and treat accordingly

A fall assessment tool indicated that Resident #40 had been assessed as a medium risk for falls.

Interview with Registered staff and Personal Support staff in Resident #40's home area and who provide direct care to the resident indicated, that the resident is very restless when in bed and is known to be a risk for rolling out of bed. For those reasons the resident's bed is placed at the lowest level to the floor. Fall mats are placed on either side of the resident's bed to protect the resident should the resident roll from the bed to the floor. No bed rails are to be used for this resident.
Battery run bed exit sensors alarms are to be placed on both sides of the foot board of the bed and are to be functioning.
Interview with staff, who put Resident #40 to bed on both dates, indicated the staff had turned on the sensors and that the sensors were functioning.

Resident #40's two falls from the bed without the bed exit sensors alarms going off is evidence that these devices are not appropriate as a falls mitigation strategy for this resident. [s.30.(1)2]

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. 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 has failed to comply with LTCHA, 2007,s.6(7), by not ensuring that Resident #12's care was provided to the resident as specified in the plan, specific to a dietary supplement.

Resident #12 is identified as a high nutritional risk.
During an interview, the Dietitian indicated that Resident #12 remains below desired body weight, so further weight gain is desirable. The Dietitian also indicated that Resident #12 has a physician's order for a dietary supplement and this information has been communicated to the staff using the diet binder and in the nutritional care plan for Resident #12.

Review of the medication records indicated Resident #12 had a physician order to receive a dietary supplement daily. Review of the nutritional care plan indicated that Resident #12 is to be provided a dietary supplement daily.

Review of the diet binder located at the Servery in the resident's home area, indicated that Resident #12's diet included a dietary supplement daily. The Food/Fluid Monitoring Tool was reviewed and there was no documentation indicating Resident #12 had received a dietary supplement daily.

During an interview, RN #113 and PSW #111 indicated they have not provided or observed Resident #12 receive a dietary supplement daily.
During an interview, the full time, Food Service Aid (FSA) #136 indicated no awareness that Resident #12 required a dietary supplement daily, even though the diet binder located at the Servery in the resident's home area indicated that Resident #12's diet included a dietary supplement daily. [s. 6.(7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Resident #12 and all residents who receive a prescribed nutritional supplement are provided the supplement as indicated in the resident's plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Log O-001024-14

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident(CIR) was submitted regarding incompetent/improper care of Resident #34.

A review of the CIR, the licensee's investigation notes and the clinical record indicated that Resident #34 sustained a bruise when the resident was being transferred to bed by Staff #128.
Review of the resident's plan of care and the licensee's investigation indicated that Resident #34 was to be assisted by two people using a mechanical lift when transferring to and from bed.

Staff #128 transferred the resident to bed, unassisted and without using a mechanical lift as indicated in the Resident's plan of care. The Resident sustained a bruise during the improper transfer. [s. 36.]

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 staff use safe transferring when assisting residents as indicated in the residents' plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. Log O-002750-15

The licensee has failed to ensure that floor mats used in the falls prevention and management program were readily available at the home for Resident #18.

A Critical Incident was submitted after Resident #18 fell and was transferred to the hospital for further assessment and treatment.

Resident #18 has a history of falls and was ambulatory with a walker prior to the fall.

Interventions were put in place after each fall. The resident's Power of Attorney(POA) requested floor mats be placed at the bedside due the resident's frequent falls.

In an interview, Staff #101 indicated that they was unable to locate floor mats on the unit when the resident's POA requested and the RN in charge was also unable to locate floor mats for Resident #18.

Staff #101 informed the POA that floor mats could not be located and that a referral would be made to the physiotherapist so that they could be obtained.

On the day after the POA made the request for the floor mats, and before floor mats were implemented, Resident #18 was found on the floor beside the bed. The resident was sent to the hospital for further assessment and treatment for an injury sustained due the fall. [s. 49. (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 to ensure that equipment, supplies, devices and assistive aids are readily available at the home and that staff are aware of the location of these supplies and assistive devices and that staff are able to easily access the supplies and assistive devices, to be implemented voluntarily.

WN #6: 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. Log O-002496-15

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 (b) is complied with. O. Reg. 79/10, s. 8 (1)

The licensee policy ADM-01-03-05, Prevention, Reporting and Investigation of Abuse and Neglect - Internal Reporting and Investigation indicates:
Staff members who witness or who have been notified of alleged abuse will immediately report to a supervisor or a manager.

A Critical Incident Report was received regarding an allegation of verbal abuse toward Resident #49 by Staff #137.

Staff #133 did not report the alleged incident of staff to resident verbal abuse to the licensee until two days after the alleged incident of verbal abuse had occurred. [s. 8.(1)(b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident-staff communication and response system is easily used by staff.

In an interview on September 11, 2015, the Assistant Administrator indicated that when a call bell is activated, the call shows up on the staff portable phones and at a console at the nursing station. Only one call will be displayed at a time on the screen of the portable phones. The staff must scroll through the calls and hit "done" after a call is viewed to see the next call.

On September 10, 2015, call bells for for two residents rooms were activated. PSW #118 was not aware they had been activated as the portable phone PSW#118 had was already activated and the screen on the phone was displaying the Service door.

Interview with PSWs #118, #133, #134 #135, indicated that the PSWs interviewed did not know how to scroll through the portable phone to see multiple calls.

In an interview with the Assistant Administrator and the Director of Care indicated that all staff have been educated on how to use the telephone/call system. [s. 17. (1) (a)]

WN #8: 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 has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review indicated that four identified concerns directed to the administration and the dietary departments were raised during the April 17, 2014, Residents' Council meeting. The written response from the Administrator was not provided to Resident Council related to the above identified concern until May 15, 2015.
An interview with the Residents' Council assistant and the Administrator confirmed that written responses were not provided to these concerns within the designated 10 day time frame. [s. 57. (2)]

Issued on this 24th day of November, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROLINE TOMPKINS (166), JULIET MANDERSON-GRAY (607), KARYN WOOD (601), PATRICIA MATA (571)
Inspection No. / No de l'inspection :	2015_195166_0022
Log No. / Registre no:	O-002682-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 24, 2015
Licensee / Titulaire de permis :	REGIONAL MUNICIPALITY OF DURHAM 605 Rossland Road East, WHITBY, ON, L1N-6A3
LTC Home / Foyer de SLD :	FAIRVIEW LODGE 632 DUNDAS STREET WEST, P.O. BOX 300, WHITBY, ON, L1N-5S3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marcey Wilson

To REGIONAL MUNICIPALITY OF DURHAM, 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 shall ensure that the following rules are complied with:
1. All doors leading to stairways or doors that residents do not have access to must be, i. kept closed and locked, and ii.equipped with a door access control system that is kept on at all times.

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 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).

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to non-residential areas are : equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

On September 8, 2105, the inside receiving doors, which are located in the corridor by the temporary main entrance and the workshop doors across from the elevator, were observed to be propped open, there was no staff in these areas.
Inspector #571 entered these area without restriction. These non residential areas, contain tools , chemicals and industrial items.

On September 8, 2015, during the initial tour of the Cullen Gardens home area, Inspector# 601 observed door #1E33, within the servery was not locked.
This door leads to an area behind the servery . The non residential area contains, a dishwasher, liquid dish detergent, chemicals, including peroxide, multi surface cleaner, oasis 146 multi quart liquid sanitizer, oasis 115 XP extra strength floor cleaner concentrate.
The dishwasher area has another door that was also unlocked, this door leads to a service corridor that has an elevator, garbage and laundry chute.

On September 9 and September 10, 2015, at approximately 1500 hours on both days, Cullen Gardens, door #1E33 was again observed to unlocked. There was no staff in the service area at the time of the observation.

On September 8, 2015 at approximately 1030 hours and September 10, 2015, at approximately 0840 hours, the door to a non residential area, the staff utility corridor, in the Trafalgar Square home area, was found to be unlocked. This utility corridor contains the housekeeping cart and housekeeping supplies,

including cleaning chemicals.

On September 10, 2015 at approximately 1530 hours , Inspector #571 observed the door to the Great Room to be unlocked and unoccupied. This room remains under construction and contains saws, scaffolding and other building supplies.

On September 11, 2015 at approximately 1555 hours, the door to kitchen service area, on the ground floor was observed to be propped open, Inspector #571 was able to access the non residential area, unrestricted.
On September 18, 2015 at approximately 1000 and again at 1130, the door to kitchen service area, on the ground floor was observed to be propped open.

On September 10, 2015, it was observed that the centre core stairway doors, on all three floors were able to be opened without the use of a card reader. Above the doors, that entrance each floor from the stairway , there is a motion sensor device that unlocks the door as someone passes in the stairwell. Therefore allowing the door to the stairway to become unlocked.

The staff washrooms on every home area are not locked, therefore allowing residents to access the washrooms, which do not have calls bell accessibility.

During the previous inspection of July 28, 2015, a noncompliance was issued related to doors leading to non-residential areas must be kept closed and locked when they are not being supervised by staff.

Doors leading to stairways and doors leading to non residential areas that are unlocked and or unsupervised are a potential risk to the safety and well being of residents.

(166)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

Order / Ordre :

The licensee shall ensure that Resident #40 and all other residents who presently use a bed exit sensor alarm are assessed to ensure that these alarms are appropriate to use as a falls mitigation strategy based on the residents' condition.

Grounds / Motifs :

1. The licensee has failed to ensure that any equipment, supplies, devices, assistive aids, or positioning aids used by the staff, appropriate for the resident and based on the resident's condition.

Review of clinical documentation indicated that on a specified date and time

Personal Support staff alerted the Registered Nurse that Resident #40 was found with their lower body on the mattress and head on the floor mat.
The resident was assessed by the Registered Nurse and no injuries were noted at the time of the incident.
Post fall assessment indicated that resident was last seen asleep, one half before the incident.
The assessment indicated two fall mats were in place in either side of the bed, the bed was in the lowest position to the floor, there were no bed rails on the bed.
The motion sensor alarms at the foot of the bed were turned on, but neither sensors were alarming.

On an identified date and time a second incident occurred.
Resident #40 was found positioned across the bed, with their torso on the floor mat and pelvic area on the bed.
The Registered Nurse assessed the resident and no injuries were found at the time of the incident.
Post fall assessment indicated the resident was seen asleep, one half hour before the incident.
The assessment indicated the bed was in the lowest position to the floor, the floor mats were on either side of the bed and there were no bed rails on the bed.The motion sensor alarms at the foot of the bed were turned on, but neither sensors were alarming.

The Resident's plan of care related to falls directs staff to :
-Observe resident hourly or more frequently for safety
-Bed in lowest position with 2 floor mats in place beside bedside bed and the 2 sensors on footboard to be operational.
-No bed rails
-Assess for causes of restlessness, i.e.pain and treat accordingly

Fall assessment tool indicated that Resident #40 had been assessed as a medium risk for falls

Interview with Registered staff and Personal Support staff in Resident #40's home area and who provide direct care to the resident, indicated that the resident is very restless when in bed and is known to be a risk for rolling out of bed. For those reasons the resident's bed is placed at the lowest level to floor, fall mats are placed on either side of the resident's bed to protect the resident

should the resident roll from the bed to the floor. No bed rails are to be used for this resident.
Battery run bed exit sensors alarms are to be placed on both sides of the foot board of the bed and are to functioning.
Interview with staff who put Resident #40 to bed on the dates of both incidents indicated the staff had turned on the sensors and that the sensors were functioning.

Resident #40's two falls from the bed without the bed exit sensors alarms going off is evidence that these devices are not appropriate as a falls mitigation strategy for this resident.

(166)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 24th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROLINE TOMPKINS

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