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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Dec 22, 2015;	2015_258519_0028 (A2) (Appeal\Dir#: DR #051)	018506-15	Resident Quality Inspection

Licensee/Titulaire de permis

FAIRVIEW MENNONITE HOME
515 Langs Drive CAMBRIDGE ON N3H 5E4

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

FAIRVIEW MENNONITE HOME
515 LANGS DRIVE CAMBRIDGE ON N3H 5E4

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

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NANCY JOHNSON (538) - (A2)(Appeal\Dir#: DR #051)

Amended Inspection Summary/Résumé de l’inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector`s order(s). The Director`s review was completed on 2105 -12-18. Order(s) were altered to reflect the Director`s review.

Issued on this 22 day of December 2015 (A2)(Appeal\Dir#: DR #051)

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

Original report signed by the inspector.

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NANCY JOHNSON (538) - (A2)(Appeal/Dir# DR #051)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 10, 11, 12, 13, 14, 17, 18, 19, 20, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Housekeeping Laundry Manager / Tena Systems Co-ordinator, the Maintenance Manager, the Resident Assessment Inventory / Minimum Data Set (RAI/MDS) Registered Practical Nurse (RPN), the Behavioural Supports Ontario (BSO) Registered Nurse (RN), the BSO Personal Support Worker (PSW), a Physiotherapy Assistant, a Dietary Aide, a Housekeeping staff, a Maintenance staff, a Registered Nurse, five Registered Practical Nurses, seven Personal Support Workers, the Receptionist, several Residents and Families.

The Inspectors toured the home, observed meal service, medication passes, medication storage area and care provided to residents, reviewed medication records and plans of care for specified residents, reviewed policies and procedures, observed recreational programming, staff interaction with residents and general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

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

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

Observations completed during the initial tour of the home on a specified date, and on two home areas with the Environmental Services Supervisor identified the following:

A) The floor in a common room on a specified home area had a black ring around the perimeter of the room.

At the entrance to a common room on a specified home area the threshold was heavily soiled.

There were holes in the flooring in a common room that were filled with a black substance and the floor at the doorway to another room close by was heavily soiled with a black substance around the door frame.

A mat covering the floor in a common room was heavily soiled with black dirt and loose debris.

The walls of a common room were soiled with debris.

The flooring in a common room had a heavy build up of a black substance under the edge of the counter and around the perimeter of the area.

B) The flooring in other common home areas had heavy black marks around the perimeter of the rooms.

C) In a common home area there was a lamp that was soiled and the lamp shade was dirty and in disrepair.

D) Observations in a common room, on a specified date, identified a black perimeter around the room, black dirt around the base of door frames, and a black substance under and around an appliance. The appliance was soiled with visible debris and the handle was sticky.

E) Observation of a home area spa identified that in the shower area there was a gray perimeter around the room where dirt had collected.

F) On a specified date, the tracks at the door of the elevator were observed to be

heavily soiled with loose debris and dirt.

Interview with the Maintenance staff member confirmed that the floor areas in the common rooms were mopped once every other day by the Maintenance department. The Maintenance staff member was unable to identify who was responsible for cleaning the perimeter of the room and around door frames.

Interview with the Maintenance staff member identified that the floor in the elevator was cleaned weekly by Maintenance. The track of the door was cleaned as necessary with the last cleaning having been completed approximately one month prior to the RQI.

The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During observation on a specified date, it was observed that:

A) On a specified home area, a floor had cracks along the surface where the wall and floor connect, holes in the flooring, and a large area where the surface was rippled and patches were evident.

Three large open areas were observed in the ceiling of the room where staff reported water leaks had occurred approximately one year ago and the ceiling surface had not been repaired. Paint on the wall under one of the open areas was damaged.

The ceiling remained open and raw building materials were exposed. Dietary and Maintenance staff confirmed that the area had been left open following repairs that were initiated over a month prior to the RQI.

A counter in a common room had edges which were covered by a foam pool noodle. This was due to sharp edges that may have been harmful to those that would have potentially come in contact with it.

Interview with Dietary staff and Maintenance staff confirmed that the common room had been in this state of disrepair for approximately one month.

B) Brown wooden straight back chairs with peeling finish, and rough sticky surfaces were observed in a common room in several home areas.

C) A lift was observed in a common area with the casing on the leg broken and the rusted metal pieces of the leg exposed.

A tour of two home areas was completed with the Environmental Services Supervisor who confirmed the above concerns.

The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

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

(A2)(Appeal/Dir# DR #051)
The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

During the documentation review it was noted that Minimum Data Set / Resident Assessment Instrument (MDS/RAI) data from a specified date, stated that a Resident was frequently incontinent of bladder and usually incontinent of bowel. The MDS/RAI data from another date stated that the same Resident was incontinent of bladder and frequently incontinent of bowel. These were changes that triggered a Resident Assessment Protocol Summary (RAPS). There was no evidence of a Continence Assessment being completed since the Resident's admission date.

During the documentation review it was noted that MDS/RAI data from a specified date stated that a Resident was frequently incontinent of bladder and occasionally incontinent of bowel. The MDS/RAI data from another date stated that the same Resident was occasionally incontinent of bladder and frequently incontinent of bowel. These were changes that triggered RAPS. There was no evidence that the Resident had a Continence Assessment since their admission date.

Upon interview with the Director of Care on a specified date and time, it was confirmed that the home did have a clinically appropriate Continence Assessment on Point Click Care (PCC) but that it was not completed for these two Residents when there was a change in continence level triggered by MDS/RAI data. She stated that the changes were captured on the RAPS of the MDS/RAI and the Quarterly MDS Review in the progress notes only.

The home's policy titled, "Continence Care Bladder and Bowel" stated under procedure that each resident's bowel and bladder functioning, including individual routines and the resident's level of continence shall be reassessed with the PCC Continence Assessment when there was any change in the resident's health status that affects continence.

The licensee failed to ensure that two Residents, who were incontinent, received an assessment that included the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was

conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the Residents required. [s. 51. (2) (a)]

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. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

The licensee has failed to ensure that residents were not charged for goods and services that they were required to provide using funding from the Minister, under section 90 of the Act.

Two Residents were identified to require the use of incontinence products to promote independence and comfort related to bladder incontinence.

Interview with one Resident confirmed that they used an incontinence product and that the home billed them for the product.

Interview with the Continence Care Coordinator confirmed that the two Residents and other Residents of the home were using incontinence products as part of their plan related to incontinence and that the home was billing Residents the cost of the product that was greater than the $1.20 per resident per day provided by the Ministry of Health for incontinence products. In addition, some Residents were charged an administration fee related to the purchase of these products.

The licensee failed to ensure that Residents were not charged for goods and services that they were required to provide using funding from the Minister, under section 90 of the Act. [s. 245. 1.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

During Stage One of the Resident Quality Inspection (RQI) it was reported by a Resident on a specified date and time to an Inspector, that they at times have had to wait long periods, up to 30 - 45 minutes, before their call bell was answered and the delay in response had resulted in incontinence for the Resident.

During Stage One of the RQI it was reported by a family member on a specified date and time to an Inspector, that staff were not always available. The family member described an incident where the Resident required staff assistance, the call bell was initiated but was never responded to. The family member provided the assistance required by the Resident.

During Stage One of the RQI it was reported by a Resident on a specified date and time to an Inspector, that they required assistance to go to the bathroom. The Resident stated that they had been told they called too many times. The Resident also indicated they have been incontinent as a result of waiting for staff to come to provide assistance.

During Stage One of the RQI it was reported by a Resident on a specified date and time to an Inspector, that they had to wait long periods, up to 45 minutes, and had been incontinent of bowel and bladder as a result of having to wait. Interview with this Resident on a specified date, confirmed that they had been incontinent of bladder and bowel as a result of having to wait for staff to respond to the call bell. The Resident indicated that they were assisted with their continence needs only when they requested assistance. The Resident indicated that they had activated the call bell in the bathroom as staff are more likely to respond to that call bell. The Resident would then return to their bedside to await assistance. On two occasions the call bell was turned off without addressing the needs of the Resident.

The licensee failed to ensure that every residents right to be be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, was fully respected and promoted. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

In the progress notes and according to staff and family interview, a Resident did not require an assistive device.

In the Resident's care plan, it was noted that staff were to ensure the assistive device was cared for and cleaned every day.

Upon interview with a Personal Support Worker (PSW) on a specified date and time, it was stated the Resident did not require the use of this assistive device.

Upon interview with a Personal Support Worker (PSW) and a Registered Practical Nurse (RPN)on a specified date and time, it was confirmed that the Resident did not have or use this assistive device. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A Resident had a witnessed fall on a specified date and time and did not sustain an injury. A Falls Risk Assessment Tool (FRAT) indicated on a specified date and time, that the Resident was an Orange leaf or a moderate falls risk.

A Resident had another witnessed fall on a specified date and time. The Resident was transferred to hospital where it was determined that the Resident sustained a fracture. The FRAT completed on a specified date and time hours, indicated the Resident was a Green leaf or low falls risk.

Upon review of the Resident's care plan, it was noted that the Resident's fall risk was a Red leaf or high risk.

Upon review of the Resident's Resident Assessment Protocol Summary (RAPS) on a specified date, it was noted that the Resident was deemed a high risk for falls.

During resident observation on a specified date and time, it was noted that a Green leaf was outside the Resident's room door.

Upon interview with the Director of Care on a specified date and time, it was confirmed that the Resident was a high risk for falls and there should have been a Red leaf outside the Resident's room door. She also stated that a updated RAPS should have been done on the date when it was triggered. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

During Stage One of the Resident Quality Inspection (RQI) it was noted during observations on two specified dates and times, that a Resident had two assistive devices.

During review of the care plan, there was no mention of the assistive devices being utilized for this Resident.

Upon interview with a Personal Support Worker (PSW) on a specified date and time, it was stated that the Resident used one of the assistive devices for getting out of bed and did not use the other assistive device. She stated that the direct care staff just

kept it there regardless whether the Resident used it or not.

Upon interview with the Director of Care on a specified date and time, it was confirmed that the Resident had the assistive devices but that she was unaware that the Resident required the use of them. Due to this reason, it was not included in the Resident's plan of care.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to a Resident when the Resident was using assistive devices and it was not included in the Resident's plan of care. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, 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. The licensee failed to ensure that 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, is complied with.

The home's policy titled, "Fall Prevention", stated that the interdisciplinary team will conduct the Falls Risk Assessment Tool (FRAT) within 24 hours of admission, following each fall, and if a falls Resident Assessment Protocol (RAP) was triggered with any Resident Assessment Instrument (RAI) assessment.

The most recent RAI Assessment completed on a specified date for a Resident, had identified a risk of falls with the Resident having sustained a fall previously and a RAP was completed that indicated the Resident was at risk of falls due to a demonstrated increase in attempts to self transfer. A FRAT had not been completed for the Resident since the previous year.

Point Click Care (PCC) identified the FRAT to be overdue for this Resident.

Interview with the RAI Coordinator confirmed that a FRAT should have been completed when the Resident was identified to be at risk of falls during the last RAI assessment.

Interview with the Director of Care (DOC) confirmed that a FRAT was to be completed with each fall but was not completed for that Resident in the previous two weeks. A Resident sustained falls twice in 2014 and once in 2015. No FRATs were completed following these falls as required in the home's policy or within the two week period immediately preceding the falls as identified by the DOC.

The licensee failed to ensure that the the Fall Prevention policy was complied with when a Resident was not assessed post fall and when a Falls RAP was triggered with the most recent RAI assessment. [s. 8. (1) (b)]

2. The licensee failed to ensure that 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home's policy titled, "Fall Prevention", stated that the interdisciplinary team will conduct the Falls Risk Assessment Tool (FRAT) within 24 hours of admission,

following each fall and if a falls Resident Assessment Protocol (RAP) was triggered with any Resident Assessment Instrument (RAI) assessment.

A Resident was documented to have sustained multiple falls in 2015. Record review confirmed by the Director of Care (DOC) identified that for 76% of the falls sustained by the Resident, no Falls Risk Assessment Tool (FRAT) was completed.

The home's policy also indicated under Post Fall Management that the Resident was to be monitored for 72 hours after a fall and staff were to document in Point Click Care (PCC) as a Falls Summary Note linked to the actual fall note.

Record review of the multiple falls sustained by the Resident in 2015 identified that 15% of the required Falls Summary Notes were not completed.

The licensee failed to ensure that the Fall Prevention policy was complied with for the Resident. [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 that 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, is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

During Stage One observations on a specified date and time, it was noted that a Resident had two rails in the raised position. Repeat observations done on a later date and time, revealed that the above bed rails were still in the raised position.

Upon interview with a Personal Support Worker (PSW) on a specified date and time, it was stated by the PSW that the Resident used one rail for getting up and that the other bed rail was always put up by the staff.

Upon interview with the Director of Care (DOC) on a specified date and time, it was confirmed that a bed rail assessment had not been completed for the Resident as she was not aware that staff were raising the bed rails and that the Resident was requiring the use of the bed rails. [s. 15. (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 where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #8: 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 failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

On a specified date and time, it was observed that the call bell in a specified room, which was activated by a push button at the end of the cord, was laying on the floor under the bed. The Resident was ambulatory in the room at the time.

Registered staff interviewed confirmed that the call bell was not accessible to the Resident and that it would be the home's practice to attach the call bell to the top of the bed linens but there was no clip to secure this call bell in place.

The license failed to ensure that the resident-staff communication and response system in a specified room could be easily seen, accessed and used by the resident, staff and visitors at all times. [s. 17. (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 home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #9: 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. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident had been assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Resident was identified to be at risk for falls and sustained falls on two dates in 2014 and one date in 2015.

Interview with the Director of Care (DOC) confirmed that the Fall Risk Assessment Tool (FRAT) in Point Click Care (PCC) was to be completed when a Resident sustained a fall, if they had not had an assessment completed in the previous two weeks.

No FRAT could be identified for the Resident, post fall on the two dates in 2014 and the one date in 2015.[s. 49. (2)]

2. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Record review confirmed that the Resident sustained multiple falls in 2015.

The Director of Care (DOC) confirmed that for the majority of falls sustained in 2015 Fall Risk Assessment Tools (FRATs) were not completed for the Resident. The DOC indicated that FRATs should be completed post fall, if one had not been completed in the previous two weeks.

The home's policy titled, "Fall Prevention", indicated that FRATs would be completed following each fall.

The licensee failed to ensure that the Resident received a post-fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident has fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A Resident was identified on a specified date to have an area of altered skin integrity that was dark in color. Record review identified that no skin and wound assessment was completed in relation to the identified area.

Minimum Data Set (MDS) assessments completed twice in 2015, identified that the

Resident had an area of altered skin integrity.

Interview with the Director of Care (DOC) confirmed that an area of altered skin integrity, such as the one described for the Resident on the specified date, would require the completion of a Skin and Wound Assessment on Point Click Care (PCC) and that no assessment had been completed for the Resident.

The licensee failed to ensure that a resident exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration were implemented.

A Resident was identified to have an area of altered skin integrity on a specified date. The area was confirmed to be present and identified as an altered skin integrity in two Minimum Data Set (MDS) assessments and Resident Assessment Protocols (RAPS).

Record review, confirmed with the Director of Care, identified that no Dietary Referral was completed for the Resident in relation to this area of altered skin integrity.

The Registered Dietitian (RD) assessed the Resident on a specified date, and identified no skin breakdown and completed a quarterly assessment on a specified date and reported no reports of skin breakdown.

The licensee failed to ensure that the Resident who exhibited altered skin integrity was assessed by a Registered Dietitian. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff.

A Resident was identified on a specified date to have an area of altered skin integrity.

Minimum Data Set (MDS) assessment completed twice in 2015, confirmed the presence of an area of altered skin integrity.

Interview with the Director of Care (DOC) confirmed that weekly wound assessments should have been completed for this area of altered skin integrity from the time it was identified early in 2015. Record review confirmed by the DOC found no weekly wound assessments were completed for this area of altered skin integrity.

The licensee failed to ensure that the Resident who exhibited an area of altered skin integrity was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 A) to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

B) to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a Registered Dietitian who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration are implemented.

C) to ensure that residents who exhibit altered skin integrity, including pressure ulcers, are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff who provided direct care to Residents received annual training on falls prevention and management as a condition of continuing to have contact with residents.

Record review and interview with the Director of Care (DOC) identified that not all staff had participated in annual training provided on Falls Prevention and Management.

Record review identified that for 2015, the training related to Falls Prevention and Management had not been completed by 68% of the staff of the home. The DOC confirmed that for 2014, 23% of staff had failed to participate in training related to Falls Prevention and Management. [s. 221. (1) 1.]

2. The licensee has failed to ensure that staff who provided direct care to residents received annual training on skin and wound care as a condition of continuing to have contact with residents.

Record review and interview with the Director of Care (DOC) confirmed that not all staff have received training on Skin and Wound care.

From November 2014 to August 2015 23% of staff who provided direct care to Residents had not completed annual training on Skin and Wound care offered by the home through the Itacit Training.

The DOC indicated that less than 75% of staff received training on Skin and Wound care in 2014.

The licensee failed to ensure that staff who provided direct care to Residents received annual training on Fall Prevention and Management and Skin and Wound care as a condition of continuing to have contact with Residents. [s. 221. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff who provide direct care to residents receive annual training on falls prevention and management and skin and wound care, as a condition of continuing to have contact with residents, to be implemented voluntarily.

WN #12: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program.

Interview with a Registered staff on a specified date and time, revealed that all education is provided online through iTasks and it is the expectation of the home that staff complete the education within a certain timeframe, that the education included hand hygiene practices, that the completion is monitored, and that staff should be completing hand hygiene between resident's care.

Observation was completed of the Medication administration on a specified date and time for a Resident. The observation revealed that the Registered staff assisted a Resident in another area to pick up a paper off of the floor, and then returned to the medication cart and proceeded to prepare and administer medication. The Registered staff did not complete hand hygiene in between the two activities.

The home's policy, titled "Infection Control" – Staff education, revealed under "Handwashing technique" that handwashing was to occur after treatment of each resident, between residents, before meals, after going to washroom, sneezing, blowing nose, and wiping of the nose and hands.

Under iPharm Policies and Procedures titled "Medication Systems"- Administering Oral Medications, it was revealed under "Procedure" that basic hand washing techniques should be carried out.

The Registered staff confirmed that the home's expectation was that all staff were to complete hand hygiene in between Resident care and administration of medication. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

A Resident was identified to have altered skin integrity on a specified date.

Minimum Data Set (MDS) assessment and Resident Assessment Protocols (RAPs) completed twice in 2015, confirmed the presence of an area of altered skin integrity.

The plan of care for the Resident addressed risk of altered skin integrity, but did not address the area of altered skin integrity to the Resident's specified body area, or include interventions initiated.

Interview with the Director of Care (DOC) confirmed that the Resident's area of altered skin integrity should have been included in the plan of care.

The licensee failed to ensure that the plan of care for the Resident was based on an interdisciplinary assessment with respect to the Resident's altered skin integrity. [s. 26. (3) 15.]

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to minimize the restraining of residents was complied with.

During Stage One observations of the Resident Quality Inspection (RQI) made on a specified date and time, it was noted that a Resident had one bed rail raised and a restraint. The physician's order for restraints on a specified date, was reviewed and stated that the Resident was to use the restraint and bed rails for safety.

Upon review of the Resident's documentation it was noted that there was a "Monthly Evaluation of Restraining Devices" completed for every month so far in 2015 but that two months were missing on Point Click Care.

Upon interview with the Director of Care (DOC) on a specified date and time, it was confirmed that the "Monthly Evaluation of Restraining Devices" was not done for two months in 2015 as the staff assigned to do these assessments were off duty at the time.

The home's policy titled, "Least Restraint", stated under ongoing use of restraints that the Registered Staff (RN/RPN) will document change in resident response to restraint use, on the multidisciplinary progress notes. Monthly assessment is scheduled in Point Click Care (PCC) to be completed by the RN/RPN.

The licensee failed to ensure that the "Least Restraint" policy was complied with when the "Monthly Evaluation of Restraining Devices" was not completed for a Resident for two months in 2015. [s. 29. (1) (b)]

WN #15: 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 failed to ensure that 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 the licensee kept a written record relating to each evaluation under paragraph 3 that included 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.

Record review and interview with the Director of Care (DOC) confirmed that the written record for program evaluations, including Skin and Wound, Falls, Pain and Palliative Care, Continence, and Behaviour Supports Ontario, did not include in the summary of changes made to programs, the date that those changes were implemented. [s. 30. (1) 4.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written record of each annual evaluation of the staffing plan including 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.

Upon review of the Nursing Department Staffing Plan it indicated the policy was reviewed in August 2015 by the Director of Care (DOC). Interview with the DOC confirmed that there was no written record of the annual evaluation of the staffing plan. [s. 31. (4)]

WN #17: The Licensee has failed to comply with LTCHA, 2007, 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 ensure that the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Upon review of the Resident Council Meeting minutes it was noted that there were six Resident concerns that were put into writing at a meeting held in 2015. These concerns were responded to by the Administrator sixteen days later, in writing. The response time frame exceeded ten days.

Upon interview with the Administrator on a specified date and time, it was confirmed that the response in writing to the concerns raised by Resident Council exceeded the ten day legislative requirement. [s. 57. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, there are schedules and procedures in place for routine, preventive and remedial maintenance.

Interview with a Maintenance staff member and the Environmental Services Manager confirmed that the home did not have schedules and procedures in place for routine, preventative and remedial maintenance in the Long-Term Care Home.

Interview confirmed that the Maintenance department depended on nursing and housekeeping staff to report deficiencies related to maintenance in the home. Heating, Ventilation and Air Conditioning units (HVAC) and mechanical systems in the home were routinely maintained by external providers.

Stage One of the Resident Quality Inspection (RQI) identified that some of the drains in the sinks in the home areas, and in some Resident rooms, had rusted drains. Door frames in several areas were observed to have paint chipped and metal surfaces exposed.

The licensee has failed to ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance. [s. 90. (1) (b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

Interview with the Director of Care (DOC) on a specified date, confirmed that the home has not done a yearly evaluation of their Prevention of Abuse and Neglect policy including an analysis of every Resident to Resident incident of abuse, as well as any changes and improvements that have been implemented. [s. 99. (b)]

Issued on this 22 day of December 2015 (A2)(Appeal/Dir# DR #051)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : NANCY JOHNSON (538) - (A2)(Appeal/Dir# DR #051)

Inspection No. / No de l'inspection : 2015_258519_0028 (A2)(Appeal/Dir# DR #051)

Appeal/Dir# / Appel/Dir#: DR #051 (A2)

Log No. / Registre no. : 018506-15 (A2)(Appeal/Dir# DR #051)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Dec 22, 2015;(A2)(Appeal/Dir# DR #051)

Licensee / Titulaire de permis : FAIRVIEW MENNONITE HOME
515 Langs Drive, CAMBRIDGE, ON, N3H-5E4

LTC Home / Foyer de SLD : FAIRVIEW MENNONITE HOME
515 LANGS DRIVE, CAMBRIDGE, ON, N3H-5E4

Name of Administrator / Nom de l'administratrice ou de l'administrateur : JIM WILLIAMS

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

To FAIRVIEW MENNONITE HOME, 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 :

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

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

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

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

Order / Ordre :

(A2)(Appeal/Dir# DR #051)
NOTE: This order(s) have been altered to reflect a decision of the Director on a review of the inspector s orders. The Directors review was completed on 2015-12-18.

The licensee shall clean the Blair and Preston dining rooms and the Blair servery: paying particular attention to the perimeter of these rooms and to areas where food is stored, served and prepared.

The licensee shall:

(a) repair and or replace the counter of the servery of the Blair dining room and keep it in a good state of repair;

(b) repair the opening in the ceiling above the Blair home servery;

(c) repair and or replace the damaged flooring, including the areas with bubbling, in the Blair dining room; and repair the lift in the Hespler shower, ensuring there is a protective casing around the leg where the rusty metal is exposed.

Grounds / Motifs :

1. Previously issued as a Written Notification (WN) on February 21, 2014.

The scope of this issue was wide spread involving four of four dining rooms observed. The severity was determined to be a potential for actual harm (level two) as the areas of concern included food service areas and dining rooms.

The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

Observations completed during the initial tour of the home on a specified date and on two home areas with the Environmental Services Supervisor identified the following:

A) The floor in a comon room on a specified home area had a black ring around the perimeter of the room.

At the entrance to a common room on a specified home area the threshold was heavily soiled.

There were holes in the flooring in a common room that were filled with a black substance and the floor at the doorway to another room close by was heavily soiled with a black substance around the door frame.

The mat covering the floor in a common room was heavily soiled with black dirt and loose debris.

The walls of a common room were soiled with debris.

The flooring in a common room had a heavy build up of a black substance under the edge of the counter and around the perimeter of the area.

B) The flooring in other common home areas had heavy black marks around the perimeter of the rooms.

C) In a common home area there was a lamp that was soiled and the lamp shade was dirty and in disrepair.

D) Observations in a common room, on a specified date, identified a black perimeter around the room, black dirt around the base of door frames, and a black substance under and around an appliance. The appliance was soiled with visible debris and the handle was sticky.

E) Observation of a home area spa identified that in the shower area there was a gray perimeter around the room where dirt had collected.

F) On a specified date, the tracks at the door of the elevator were observed to be heavily soiled with loose debris and dirt.

Interview with the Maintenance staff member confirmed that the floor areas in the dining rooms were mopped once every other day by the Maintenance department. The Maintenance staff member was unable to identify who was responsible for cleaning the perimeter of the room and around door frames.

Interview with the Maintenance staff member identified that the floor in the elevator

was cleaned weekly by Maintenance. The track of the door was cleaned as necessary with the last cleaning having been completed approximately one month prior to the RQI.

The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During observation on a specified date it was observed that:

A) On a specified home area, a floor had cracks along the surface where the wall and floor connect, holes in the flooring, and a large area where the surface was rippled and patches were evident.

Three large open areas were observed in the ceiling of the room where staff report water leaks had occurred approximately one year ago and the ceiling surface had not been repaired. Paint on the wall under one of the open areas was damaged.

The ceiling remained open and raw building materials were exposed. Dietary and Maintenance staff confirmed that the area had been left open following repairs that were initiated over a month prior to the RQI.

A counter in a common room had edges which were covered by a foam pool noodle. This was due to sharp edges that may have been harmful to those that would have potentially come in contact with it.

Interview with Dietary staff and Maintenance staff confirmed that the common room had been in this poor state of repair for approximately one month.

B) Brown wooden straight back chairs with peeling finish, and rough sticky surfaces were observed in a common room in several home areas.

C) A lift was observed in a common area with the casing on the leg broken and rusted metal pieces of the leg exposed.

A tour of two home areas was completed with the Environmental Services Supervisor

who confirmed the above concerns.

The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. (192)

2.

(192)

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

Apr 29, 2016(A1)

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. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall ensure that a Continence Assessment is completed for two identified Residents, and all other incontinent residents, using a clinically appropriate assessment instrument that is specifically designed for the assessment of incontinence.

Grounds / Motifs :

1. The scope of this issue was widespread (two of two residents reviewed). The severity related to this legislation was a potential for actual harm (level two), as there was no assessment of the incontinence pattern and the potential to restore function for two Residents.

The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

During the documentation review it was noted that Minimum Data Set / Resident Assessment Instrument (MDS/RAI) data from a specified date, stated that a Resident was frequently incontinent of bladder and usually incontinent of bowel. The MDS/RAI data from another date stated that the same Resident was incontinent of bladder and frequently incontinent of bowel. These were changes that triggered a Resident Assessment Protocol Summary (RAPS). There was no evidence of a Continence Assessment being completed since the Resident's admission date.

During the documentation review it was noted that MDS/RAI data from a specified date stated that a Resident was frequently incontinent of bladder and occasionally incontinent of bowel. The MDS/RAI data from another date stated that the same Resident was occasionally incontinent of bladder and frequently incontinent of bowel. These were changes that triggered RAPS. There was no evidence that the Resident had a Continence Assessment since their admission date.

Upon interview with the Director of Care on a specified date and time, it was confirmed that the home did have a clinically appropriate Continence Assessment on Point Click Care (PCC) but that it was not completed for these two Residents when there was a change in continence level triggered by MDS/RAI data. She stated that the changes were captured on the RAPS of the MDS/RAI and the Quarterly MDS Review in the progress notes only.

The home's policy titled, "Continence Care Bladder and Bowel" stated under procedure that each resident's bowel and bladder functioning, including individual

routines and the resident's level of continence shall be reassessed with the PCC Continence Assessment when there was any change in the resident's health status that affects continence.

The licensee failed to ensure that two Residents, who were incontinent, received an assessment that included the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the Residents required. [s. 51. (2) (a)]

(519)

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

Dec 30, 2015

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:

1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,

i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and

ii. the Minister under section 90 of the Act.

O. Reg. 79/10, s. 245.

Order / Ordre :

The licensee shall ensure that no resident is charged for incontinent products that the home is to provide using funding from the Minister under section 90 of the Act.

Grounds / Motifs :

1. The scope of this issue was wide spread involving all residents using incontinence products (level three). The severity was a potential for actual harm (level two) related to the potential of financial burden for the residents involved.

The licensee has failed to ensure that residents were not charged for goods and services that they were required to provide using funding from the Minister, under section 90 of the Act.

Two Residents were identified to require the use of incontinence products to promote independence and comfort related to bladder incontinence.

Interview with one Resident confirmed that they used an incontinence product and that the home billed them for the product.

Interview with the Continence Care Coordinator confirmed that the two Residents and other Residents of the home were using incontinence products as part of their plan related to incontinence and that the home was billing Residents the cost of the product that was greater than the $1.20 per resident per day provided by the Ministry of Health for incontinence products. In addition, some Residents were charged an administration fee related to the purchase of these products.

The licensee failed to ensure that Residents were not charged for goods and services that they were required to provide using funding from the Minister, under section 90 of the Act. [s. 245. 1.]

(192)

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

Dec 30, 2015(A1)

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

Ministère 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

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 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
Toronto ON M5S 2B1
Télécopieur : 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 22 day of December 2015 (A2)(Appeal/Dir# DR #051)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NANCY JOHNSON - (A2)(Appeal/Dir# DR #051)

Service Area Office /
Bureau régional de services : London