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
Jun 10, 2015;	2015_258519_0010 (A1)	L-001829-15	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

FOREST HEIGHTS
60 WESTHEIGHTS DRIVE KITCHENER ON N2N 2A8

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

BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for the submission of a lighting plan was extended from May 30, 2015 to September 1, 2015.

Issued on this 10 day of June 2015 (A1)

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

Original report signed by the inspector.

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

BERNADETTE SUSNIK (120) - (A1)

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): February 18, 19, 20, 23, 24, 25, 26, 27, March 2 / 2015

The following Critical Incident Inspections were done concurrently with this Resident Quality Inspection (RQI): #003030-15, # 002390-15, # 000094-15, # 001798-15, # 001809-15

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Directors of Care (4), the Wound Care Nurse, the Behavioural Supports Ontario(BSO) Nurse, the Programs Manager, the Environmental Services Manager, the Education Coordinator, the Infection Control Designate, the Food Services Supervisor, the Dietician, Dietary Aides, the Cook, the Housekeeping staff, the Maintenance staff, Registered Nurses, Registered Practical Nurses, and Personal Support Workers.

The Inspectors also 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 policy and procedures, observed recreational programming, staff interaction with residents, took illumination measurements, and observed general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

25 WN(s)
12 VPC(s)
7 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 219. (4)	CO #004	2014_226192_0010	532

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 #14: The Licensee has failed to comply with LTCHA, 2007, 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).

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

Findings/Faits saillants :

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

Under the plan of care for a Resident it was indicated for a specific treatment to take place while the Resident was in bed.

This Resident was observed to be positioned in bed. None of the indicated treatments mentioned in the Resident's plan of care were in place.

Two staff repositioned the Resident from the left side to the right side. Interview with one of the Personal Support Workers confirmed that these interventions were not being used.

The licensee failed to ensure that care set out in the plan of care for a Resident was provided to the Resident as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

A Resident had a Minimum Data Set(MDS)evaluation done where it was noted that the Resident was frequently incontinent of bowel and incontinent of bladder. On the admission note to the home, it was documented that the Resident was continent of bladder and bowels. This was updated later the next day that the Resident was incontinent of urine during the night.

Upon interview with a Registered Practical Nurse, it was confirmed that the Resident is continent of bowels and frequently incontinent of bladder.

The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary when the information available on continence changed on a Resident and the care plan was not updated. [s. 6. (10) (b)]

3. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

A Resident was observed on February 19, 24, and 25, 2015 with a quarter length bed rail centered on the right side of the bed and a quarter bed rail raised to the assist position on the left side of the bed.

The bed assessment completed by the home and dated December 31, 2014 indicated that the Resident had bed rails removed a few months earlier.

Interview with an Assistant Director of Care (ADOC) and the Resident confirmed that bed rails were reapplied to the bed approximately two weeks ago. A review of progress notes identified that a consent for bed rail use was documented as being signed.

Record review and interview with an ADOC confirmed that use of bed rails is not included in the plan of care for this Resident.

The licensee failed to ensure that when a Resident was identified to require the use of bed rails, the plan of care was reviewed and revised to include this change in the Resident's care needs. [s. 6. (10) (b)]

4. The licensee has failed to ensure that a Resident was reassessed and the plan of care reviewed and revised when the Resident's care needs changed.

Interview and record review confirmed that a Resident had a history of negative behaviours. Due to these behaviours the Resident's means of transporting themselves around was removed by the home.

Interview with staff and the Resident confirmed that the Resident was totally dependent on staff for mobility when his/her means of transportation was removed.

An agreement was put in place, and terms agreed to, by the home and the Resident to receive his/her means of transportation back.

The Resident demonstrated responsive behaviours, following an interaction with another Resident, resulting in the agreement being broken. The Resident's plan of care did not provide direction for staff intervention, did not identify the known triggers for this Resident and staff failed to intervene in a manner that would deescalate this Resident.

Following the incident the agreement was invoked and the means of his/her transportation was removed from use making the Resident totally dependent on staff for mobility for a period of six days.

Interview with the Director of Care (DOC) and an Assistant Director of Care (ADOC), confirmed that the Resident has known triggers that increase their behaviours , however the plan of care was not reviewed and revised to include the known triggers and interventions to deescalate the Resident.

The licensee failed to ensure that a Resident was reassessed and the plan of care reviewed and revised with changes in their care needs. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with food and fluids that were safe, adequate in quantity, nutritious and varied.

On a specified date, the consistency of the puree sausage was observed to be coarse and have chunks in it. When tasted, small pieces of sausage were evident and the texture was not smooth.

Dietary Aides in specified dining rooms first sitting confirmed that the texture of the puree sausage was not smooth and when asked if it was the puree textured, they originally reported it to be minced texture. Both Dietary Aides confirmed that the texture was in fact puree texture. Residents during first sitting in specified dining rooms were served the texture posing a potential choking risk.

The Inspector notified the Food Service Supervisor and the puree texture was removed from the floors and pureed to a smooth consistency for Residents on second sitting. The Food Service Supervisor confirmed that the texture was coarse and not a suitable puree texture.

The recipe for puree textured sausage indicated that the sausage would be combined with 3/4 gravy and blended until smooth. The recipe indicated that the puree sausage was to be blended until the texture reached pudding like consistency. The Cook reported that the sausage was pureed with a little bit of water.

The licensee failed to ensure that Residents requiring puree texture were served food that was safe. [s. 11. (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 residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #7: 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. Where the Act or this regulation required the licensee of the 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 it was complied with.

Previously issued as a Compliance Order regarding the Weight Management policy not being complied with on May 8, 2014 during an RQI inspection.

The home's Height Measurement and Weight Management policy, LTC-G-60 dated June 2014, indicated that each Resident's height would be measured at a minimum annually and each Resident's weight would be taken at a minimum monthly. Residents would be weighed and the weight documented by the 7th day of each month. If a weight loss or gain was 2.0 kilograms or greater from the preceding month, the weight would be confirmed immediately. The weight record would be reviewed monthly. A nutrition referral to the Registered Dietitian would be completed and the information documented in the progress notes for weight loss or gain of greater than or equal to 5 % of total body weight over one month.

a) A review of Residents clinical health records indicated that 10 of 10 Residents did

not have a height taken and recorded annually.

Interview with the home's Registered Dietitian confirmed that annual heights were not completed for each Resident. The Registered Dietitian reported that a process to take Resident's heights on their annual assessments had recently been initiated in January 2015.

b) A review of Resident's clinical health records indicated that 11 Residents reviewed did not have monthly weights taken and recorded.

The home's Registered Dietitian confirmed that the monthly weights were not taken and recorded for the identified months for each of the identified Residents. The Registered Dietitian confirmed that the weights should have been taken and recorded in point click care under the weight tab.

c) A review of a Resident's clinical health record indicated that the Resident experienced a significant weight loss of 10.2% of total body weight over one month, however, there was no referral sent to the home's Registered Dietitian. The Registered Dietitian confirmed that they did not receive a nutrition referral for the Resident's significant weight loss, however, reported that a nutrition referral should have have been completed for the Resident's significant weight loss.

A Resident experienced a weight loss of 3.5 kilograms, however, weight records indicated there was no reweigh taken and documented. This was confirmed by the Registered Dietitian who confirmed that any weight loss or gain of 2.0 kilograms should have a reweigh taken and documented in point click care under the weight tab.

d) A review of a Resident's clinical health record indicated that the Resident experienced a 7 kilogram weight gain, 10.4% of their total body weight. There was no reweigh taken and recorded and no nutrition referral completed, this was confirmed by the Registered Dietitian.

The home failed to ensure that Height Measurement and Weight Management policy, LTC-G-60, was complied with. [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 is required to ensure that

the plan, policy, protocol, procedure, strategy or system is complied with.

The home's policy titled "Revera Skin and Wound Care Program", Index LTC-E-90, dated as revised March 2014, stated under Documenting/Monitoring that a Treatment Observation Record (TOR) Initial Wound Assessment will be initiated when a Resident has any open area/wound. One TOR is to be completed for each open area/wound. The TOR Ongoing Wound Assessment is to be completed with every dressing change, at a minimum of every seven days and family communication will be documented in the progress notes including when altered skin integrity was identified, treatment initiated and interdisciplinary team involvement.

A Resident was identified in the progress notes to have altered skin integrity. No Treatment Observation Record (TOR) was initiated for this altered skin integrity and interview confirmed that no TOR was complete at a minimum of every seven days. Documentation failed to identify that the family were notified of the presence of the wound or that the wound had healed.

It is noted that a TOR Ongoing Wound Assessment was initiated related to altered skin integrity before the TOR Initial Wound Assessment was initiated.

A Resident was identified in the progress notes to have two areas of altered skin integrity. Record review and interview confirmed that the two areas were separate areas and that one Treatment Observation Record had been used for both areas. Documentation failed to identify that the family were notified of the presence of the Resident's skin breakdown. Interview confirmed that the TOR Ongoing Wound Assessment was not completed weekly.

A Resident was identified in the progress notes to have developed an area of altered skin integrity. No TOR was initiated until four days after the skin breakdown was identified.
[s. 8. (1) (b)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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 #1: 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. A Resident was observed to have a call bell that was not accessible to the Resident.

This Resident was observed to be laying in bed, the call bell was laying on the floor

under the bed, and would not be accessible to the Resident. The housekeeper was observed to wash the floor in this Resident's room. Following this the call bell was again observed to be laying on the floor under the bed.

A Registered Nurse interviewed identified that it is the expectation that the call bell be pinned to the Resident or in proximity to the Resident, so that it could be activated if necessary. [s. 17. (1) (a)]

2. A Resident was observed laying in bed between 1000 hours and 1130 hours. The Resident's call bell was observed to be pinned to the top right corner of the bed, hanging down to the floor during this period of observation. At 1047 hours the Resident was offered a beverage, their head was elevated and assistance was provided. The call bell was not repositioned to be accessible by the Resident until 1130 hours when the Resident was turned and the call bell was placed within reach of the Resident.

Interview with a family member present in the room from 1130 hours, confirmed that the call bell is often hanging on the floor or under the bed and would not be accessible to the Resident. [s. 17. (1) (a)]

3. During Stage One observations it was observed that a Resident's call bell was behind the bed and inaccessible to the Resident. This was confirmed at the time by the Resident who stated that it is often unreachable and staff do not provide the call bell to him/her when in bed.

Further observation a few days later revealed the call bell on the floor next to the Resident's bed.

The home's policy titled, " Resident/Staff Communication and Response System", LTC-K-40, dated August 2012, stated under #2 - The call bell will be accessible to the resident at all times. [s. 17. (1) (a)]

4. During Stage One of this Resident Quality Inspection (RQI), conducted on February 18, 19 and 20, 2015, fourteen of forty Residents interviewed did not have a call bell easily accessible to them.

An audit conducted on February 25, 2015 by three Inspectors identified that on the three home areas audited 41 bed side call bells were found to be inaccessible to the Residents. [s. 17. (1) (a)]

Additional Required Actions:

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

WN #20: 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. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Due to Resident complaints of short staffing, obtained during Stage One of the Resident Quality Inspection (RQI), the staffing plan was reviewed by the Inspector. An annual evaluation of the staffing plan was not available in the staffing plan binder when it was reviewed.

Upon interview with the Director of Care, it was confirmed that a written annual evaluation has not been done to her knowledge for the year 2014. [s. 31. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Resident received fingernail care, including the cutting of fingernails.

The plan of care for a Resident stated under bathing that the Resident was to have finger and toe nails trimmed on bath days.

The home's policy titled "Nail Care", LTC-H-30 effective August 2012, indicated that all Residents will have their fingernails and toenails checked at the time of their bath/shower and care provided according to their needs.

The Resident was documented to have received a bath twice in one week in February 2015. Documentation indicated that both finger and toe nails were trimmed on the

second bath date that week.

During observation of the Resident before and after the bath dates it was confirmed by the Registered Practical Nurse that the Resident had long finger nails on both hands. [s. 35. (2)]

2. The licensee has failed to ensure that the resident received fingernail care, including the cutting of fingernails.

During Stage One of the Resident Quality Inspection (RQI), it was observed that a Resident's fingernails were dirty.

Further observations made a week later revealed that the Resident had dirt under the finger nails on the right hand.

Upon interview with a Personal Support Worker (PSW), it was confirmed that the PSWs are responsible for cleaning the Resident's finger nails on their bath day.

The documentation in Point of Care (POC) under bathing, revealed that a PSW gave the Resident a shower and cleaned the Resident's nails.

A PSW confirmed the next day, in the presence of the Inspector, that the Resident's right hand finger nails had dirt underneath them the day after the scheduled bath. [s. 35. (2)]

3. The licensee has failed to ensure that a Resident received fingernail care, including the cutting of fingernails.

A Resident was observed to have long dirty finger nails.

The plan of care for the Resident indicated that finger nails are to be trimmed on bath days. Point of care (POC) documentation indicated that the Resident received a bath and that nail care had been provided.

The Resident was observed to be receiving a bath. Observation following the bath, with the Registered Practical Nurse, confirmation was obtained that the Resident's nails were long, jagged and dirty.

Interview with the Registered Practical Nurse confirmed that Personal Support

Workers are to complete nail care during bathing. [s. 35. (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 residents receive fingernail care, including the cutting of fingernails, to be implemented voluntarily.

WN #16: 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:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, annual training in skin and wound care.

Interview with the Wound Care Champion (WCC) confirmed that they would be responsible for providing staff education related to skin and wound care and that the WCC provided no education on skin and wound care in 2014.

Interview with the Education Coordinator and documentation provided, confirmed that not all staff providing direct care to Residents had received training on skin and wound care in 2014. [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 all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, annual training in skin and wound care, to be implemented voluntarily.

WN #11: 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 who exhibited altered skin integrity, including pressure ulcers or wounds had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A Resident was identified to be at high risk for altered skin integrity and developed an open skin area. Interview with the Wound Care Champion confirmed that a weekly wound assessment was not completed for this open area before it was noted to be closed.

A Resident was identified to have open skin areas. There was no documentation to support that these open area had healed, however interview with the Wound Care Champion identified that they had healed and confirmed that there was no weekly wound assessment completed on either wound.

The licensee failed to ensure that a Resident who exhibited altered skin integrity had been 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 to ensure that residents who exhibit altered skin integrity, including pressure ulcers or wounds have been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour program was evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

Interview with the Director of Care and the Registered Practical Nurse responsible for the Responsive Behaviour Program in the home confirmed that no annual evaluation of the program had been completed for 2014. [s. 53. (3) (b)]

WN #5: 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. As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, the licensee did not ensure that schedules or procedures were in place for certain preventive maintenance activities.

Maintenance services was being managed by a contracted service provider. According to the Environmental Services Manager (ESM) and the contracted service provider's maintenance policies, no specific procedure was in place to guide maintenance or designated staff in their role in conducting preventive maintenance inspections related to the condition of floors.

A) During the inspection, the flooring conditions below were observed and discussed with the ESM, some of which was known to the ESM and others that were not. No schedule of repair was in place.

i) The flooring material in a tub room was split under the tub, vanity and by the shower entrance.

ii) In a specified bathroom there was an 18 inch long crack at the baseboard/wall junction.

iii) In a tub room the floor was split under head of the tub.

iv) In a tub room, there was a 12 inch crack at the wall/floor junction that was caulked over near the toilet, and a patch of flooring in front of the shower area had one seam split.

v) In a tub room, two cracked areas were noted in the floor in front of the shower surround and when stepped on, water oozed out.

vi) In a tub room, there were 2 long cracks in the flooring on either side of the toilet (wall/floor junction) that were caulked over.

vii) Floor tiles in a bedroom were broken/uneven.

In addition, the maintenance manual did not include any information related to the on-going monitoring of the following:

B) Plumbing Fixtures – No procedure was in place to address the condition of sinks

and other components. Rusty sink drains were observed in four washrooms.
C) Windows – No procedure was in place to address the condition of windows and surrounding surfaces such as sills. The laminate on window sills in three rooms was delaminating.
D) Furnishings - Chair frames in many resident rooms were observed to have the finish worn down to an absorbent wood layer. No procedure was in place to manage this issue.
E) Doors – No procedure was in place to address the condition of doors such as the splintered bath doors that were identified in three rooms.

The maintenance manual was reviewed with respect to wall repair and painting services. The maintenance manual was reviewed and confirmation was made that a quarterly schedule and procedure E-75-15 titled "Painting", was in place, however it did not appear that the auditing component and adherence to the schedule was in place. The schedule identified that each floor be painted (touched up) quarterly, however according to the painting log maintained between April 23, 2014 and January 29, 2015, very little actual painting took place. In the time period provided, only 26 rooms had patching and painting completed. The log did not identify whether or not any bathrooms were painted or any doors or casings. The maintenance person in the home who regularly completes the painting reported that the entire home was painted over the summer of 2014 but the work was not identified in the painting log. During the inspection, Inspectors identified numerous areas requiring touch ups, repairs and painting without being able to confirm when they were last painted or repaired.

i) Bathroom door casings were rusted or had paint peeled away around a tub room and fifteen Resident rooms. Bedroom door casings were rusted or had paint peeled away around eleven rooms. A painter was hired the first week of February to paint the bedroom doors and casings, however, the painting was suspended due to an outbreak starting the week of February 23rd, 2015.

ii) Wall damage was evident behind a bed in a specified bedroom, and three specified washrooms. Wall surfaces behind toilets were not remedied when new toilets were installed over the last year. The older model toilets, when removed had old peeling wallpaper or lack of paint behind them in nine bathrooms. [s. 90. (1) (b)]

Additional Required Actions:

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

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (2) A licensee shall not allow alterations, additions, renovations, maintenance or repairs to be made to the home or its equipment that do not maintain or improve upon the functional aspects of the home or equipment. O. Reg. 79/10, s. 305 (2).

Findings/Faits saillants :

1. The licensee did not maintain or improve upon the functional aspects of the home when the tub originally installed in the Geiger Wing 1 tub room was removed prior to October 31, 2007 and replaced with a wheelchair washer unit some time thereafter instead of a tub. The bathing room, which was equipped with a toilet and a shower were being used by Residents during an inspection between February 18 and 27, 2015. The room was noted to be musty and stuffy, and the wheelchair washer was much too large for the space it occupied which was formally occupied by a bathing tub. The bathing room was designed for resident bathing activities and bathing equipment and by incorporating a non-bathing piece of fixed equipment, the functional aspects of the bathing room were not improved upon. [s. 305. (2)]

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

Findings/Faits saillants :

1. During Stage One observations of the Resident Quality Inspection (RQI) it was noted by Inspectors that some areas of the home had dim lighting.

The home was built prior to 2009 and the section of the lighting table that was applied to determine compliance is titled "All other homes".

A hand held digital light meter was used (Amprobe LM-120) to measure the lux levels in one ward bedroom and one private room, several Resident ensuite washrooms and one corridor. The meter was held a standard 30 inches above the floor and held parallel to the floor. Window coverings were drawn in the Resident bedrooms tested and lights were turned on 5 minutes prior to measuring. Areas that could not be tested due to natural light infiltration were dining rooms and common areas. Outdoor

conditions were semi-bright during the measuring procedure.

A) A Resident bedroom was measured on a specified date and the room was similarly equipped with the same light fixtures as all of the other rooms, whether private or semi-private. Each room had a wall mounted over bed light fixture consisting of fluorescent tubes and a pot light at the entrance to the room. None of the rooms were equipped with bedroom ceiling fixtures. Two different over bed lights were tested and were approximately 330-340 lux. The entrance to room was 157 lux under the pot light with a compact fluorescent bulb. The foot of bed 4 was 188 lux and the side of the bed was 148-150 lux facing the wardrobe. The area between the two beds, at the foot boards, and almost in the centre of the room was between 40-50 lux when both over bed lights were on (both top and bottom bulb). The minimum required lux level for the room in areas where activities of daily living take place such as sitting, dressing or walking is 215.28. The minimum required lux level under the over bed light is 376.73.

B) A Resident bedroom was measured on a specified date and the lux by the bed side (one side against wall), was 114, the over bed light was 280 lux and at the entrance (pot light with incandescent light bulb) was 105 lux. The minimum required lux level under the over bed light is 376.73 and 215.28 lux in areas of activity.

C) The corridor measured consisted of a drop ceiling, with recessed tube lights along the walls. The lenses over the lights were louvered. Down the centre of the corridor on a specified floor between the tub room and two rooms was 130 lux. The doors were closed to the rooms to eliminate all natural light infiltrating the corridor. The readings could not be taken down the entire length of the corridor as the windows at the end were large and the blinds could not be drawn. The minimum required lux level for corridors is 215.28 continuous consistent lighting throughout. [s. 18.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 005

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Record review and interview with the Resident, Residents witnessing the event, and staff confirmed that a Resident demonstrated negative responsive behaviours when another Resident approached them. A negative outcome resulted from the interaction.

Interview with an Assistant Director of Care (ADOC) and the Director of Care (DOC) confirmed that the one Resident approaching the other Resident was known to be a trigger for negative behaviours for this individual.

Interview and record review confirmed that interventions were not in place to minimize the risk of altercations and potentially harmful interactions between the identified trigger Resident and the other Resident.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between two Residents known not to get along. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program including assessments, reassessments, interventions and the resident's responses to interventions are documented.

During Stage One of the Resident Quality Inspection, a Resident reported that they only receive one shower a week.

In an interview a Personal Support Worker (PSW) shared the Resident's bath and shower days.

Later the Resident confirmed their bath/shower days, however, stated they did not receive their second bath of the week.

Record review and interview with a PSW confirmed that the Resident did not receive a bath on their second bath day of the week as there was a staffing shortage on the floor and staff had to pick up extra assignments, however, they would attempt to give one later in the week.

A record review with the Registered Practical Nurse and Assistant Director of Care (ADOC) revealed that there was no documentation to support that the Resident received a bath on the first bath day of the week.

The ADOC confirmed that the actions taken with respect to the Resident receiving a bath and the Resident's response to the interventions were not documented. [s. 30. (2)]

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 :

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

Previously issued as a compliance order on May 8, 2014 following the RQI inspection and reissued August 19, 2014 following a Follow up inspection.

The Minimum Data Set (MDS) revealed that a Resident was assessed as being frequently incontinent of bladder, tended to be incontinent daily but had some control present, and was usually continent of bowel less than weekly.

The previous Minimum Data Set revealed that the Resident was continent of bowel and had complete control.

When interviewed the Resident indicated that they do have bowel movements in their brief.

The Assistant Director of Care (ADOC) and record review both confirmed that the Resident did not have a continence assessment completed for bowel when it was triggered in the quarterly assessment.

In an interview the ADOC shared that once the Resident was identified and triggered through the Minimum Data Set (MDS) as being usually continent of bowel, from being completely continent, there should have been a continence assessment completed.

The ADOC shared that the continence assessment that should have been completed was the Admission/Quarterly Continence Assessment (ON), however, the Admission/Quarterly Continence Assessment (ON) was reviewed for bowel assessment and it was noted that the assessment did not include identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions related to bowels; it was an assessment for bladder only.

The ADOC reported in an interview that the staff were educated on completing the continence assessment annually or quarterly if the Residents were triggered as a change. However, she indicated that she failed to include this as part of the auditing process. When asked if she could show that assessments were being done on Residents who were triggered through MDS, or have a change in status concerning continence, the ADOC confirmed that she could not show the Inspector this information. She confirmed that the focus has been to have these assessments completed for admission as previously that was not getting done.

The ADOC confirmed that there was no continence assessment completed once the Residents were being triggered or experiencing a change in their continence status. [s. 51. (2) (a)]

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

A Resident was identified to be continent of bowel and urine at the time of admission.

Minimum Data Set (MDS) review identified that the Resident was usually continent of bowel and frequently incontinent of bladder. Interview with the Registered Practical Nurse completing the MDS review on continence, confirmed that the Resident's incontinence was not assessed using a clinically appropriate tool when the Resident was assessed to have a change in continence from continent to frequently incontinent of bladder.

The Resident, who is incontinent, did not receive an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

Additional Required Actions:

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

WN #15: 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:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal 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: 3. Every resident has the right not to be neglected by the licensee or staff.

Record review and interview confirmed that a Resident who was dependent on staff for all aspects of care and was identified to be at risk of altered skin integrity.

It was reported to an Assistant Director of Care (ADOC) that a Resident had not received care or assistance for a period of greater than seven hours.

Interview and documentation review confirmed that this Resident had not received care for the identified seven hour period. Once identified, the Resident was assessed

and care was provided for the Resident.

The licensee failed to ensure that a Resident was not neglected by staff. [s. 3. (1) 3.]

2. The licensee failed to ensure that the following rights of residents are fully respected and promoted: 3. Every resident has the right not to be neglected by the licensee or staff.

A complaint was received by the home that stated that a Resident was incontinent in their brief in the late evening hours and was not changed by staff until the next morning when day shift came on duty.

As a result of having to wait approximately 7 hours to be cleaned and changed this Resident ended up with a reddened skin area.

Upon interview with the Executive Director it was confirmed that a Resident was neglected when they were left in a soiled brief for approximately 7 hours. [s. 3. (1) 3.]

3. The licensee has failed to ensure that a Resident had the right to be afforded privacy in treatment and caring for his or her personal needs were respected and promoted.

A Resident is dependent on staff for all activities of daily living and interview with the resident confirmed that they prefer to have a bed bath twice weekly.

This Resident was observed receiving a bed bath. The door to the room was open and the privacy curtain was pulled only as far the foot of the bed. This Resident was exposed to any person entering the room.

Interview with the Registered Practical Nurse confirmed that the expectation is that staff would pull the privacy curtain around the bed and that the bedroom door would be closed, encouraging anyone entering to knock.

The licensee failed to ensure that a Resident was afforded privacy in treatment and in caring for their personal needs. [s. 3. (1) 8.]

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: 3. Every resident has the right not to be neglected by the licensee or staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, received training related to mental health issues, including caring for persons with dementia.

Interview with the Director of Care and the Registered Practical Nurse responsible for the Responsive Behaviour Program confirmed that not all staff of the home had received training related to mental health issues, including caring for persons with dementia.

Interview identified that there had been a gap in the training of staff. Gentle Persuasive Approaches (GPA) had been offered in the home and approximately eighty percent of the staff had received training. Code White related to responding to aggressive behaviours had been provided and approximately eighty percent of the staff of the home had participated in the training.

The licensee failed to ensure that that all staff who provide direct care to Residents, as a condition of continuing to have contact with Residents, received training related to mental health issues, including caring for persons with dementia. [s. 76. (7) 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 all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training related to mental health issues, including caring for persons with dementia, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used, the Resident is assessed and his or her bed system is evaluated in accordance with evidence based practices and steps are taken to prevent Resident entrapment, taking into consideration all potential zones of entrapment.

Bed systems within the home were evaluated by an external provider on March 27, 2014 and identified 49 beds that failed one or more zones of entrapment.

In a room on a specified floor, a bed was observed on a specified date to have bed rails in use. The home's evaluation of the bed dated December 31, 2014 and interview with an Assistant Director of Care (ADOC) indicated that bed rails had been zip tied in the assist position and were not in use by the Resident. The plan of care for the Resident in this room indicated that bed rails are used for bed mobility by the Resident. Observation with the ADOC on a specified date, confirmed that bed rails were in use and that the Resident had not been assessed for the use of bed rails including all zones of entrapment.

In a room on a specified date, an observation identified that the mattress surface was short for the bed frame. The home's assessment of the bed indicated that bed rails had been removed from the bed on October 1, 2014. Observation with an Assistant Director of Care confirmed that bed rails had been reapplied to the bed. Interview confirmed that the bed was not assessed for zones of entrapment when the bed rails were reapplied. Interview confirmed that the home does not have the tools required to assess beds using identified best practice and no external provider had assessed the bed. The use of bed rails was not included in the Residents' plan of care.

Interview and record review confirmed that where changes had been made to beds in relation to identified entrapment risk, beds had not been reassessed using best practice, to confirm that the entrapment risk had been addressed.

Beds in three rooms were observed with the ADOC and it was confirmed that the surfaces failed to fit the bed frame or provided potential entrapment zones that had not been identified in current assessment and interventions to prevent entrapment were not in place for Residents in those beds. Interview confirmed that consideration of the specific use of the bed rail(s) by each Resident had not been included in the assessment of the Resident and assessments included inaccurate information such as the fit of the mattress to the bed frame.

The licensee failed to ensure that where bed rails are used, the Resident is assessed and his or her bed system is evaluated in accordance with evidence based practices and steps are taken to prevent Resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the Resident is assessed and his or her bed system is evaluated in accordance with evidence based practices and steps are taken to prevent Resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #18: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any potential behavioural triggers and variations in resident functioning at different times of the day.

Interview with the Director of Care and an Assistant Director of Care identified that a specified Resident had identified triggers that impacted the Residents behaviours throughout the day.

Review of the plan of care confirmed that the identified triggers were not included in the plan of care and interventions had not been developed for staff interaction with the Resident.

The licensee failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the Resident that included any potential behavioural triggers. [s. 26. (3) 5.]

WN #3: 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 participate in the implementation of the Infection Prevention and Control program.

Previously issued as a compliance order May 8, 2014 following the RQI inspection.

On a specified date, during a lunch meal service, a Personal Support Worker (PSW) was observed to clear dishes onto a cart from multiple tables and proceeded to deliver desserts to Residents without hand hygiene.

The Assistant Director of Care (ADOC) responsible for Infection Control confirmed that the expectation was for staff to use hand hygiene in between handling dirty dishes and food served to Residents.

The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program. [s. 229. (4)]

2. The licensee failed to ensure all staff participate in the implementation of the Infection Prevention and Control program.

The home was declared to be in respiratory outbreak on February 22, 2015.

Four home areas had Residents with symptoms of illness; one had nine Residents, two areas had three Residents each, and the final area had no Residents with symptoms.

Interview with the Infection Prevention and Control Practitioner identified that the home was making every effort to cohort staff and residents to minimize the spread of infection.

Observation on a specified date identified the following concerns:

a) A Dietary Aide who was wearing gloves was observed in a specific dining room picking up dirty dishes and then interacting with the Residents and visitors, including touching the Residents with the gloved hands. No hand hygiene was completed by the Dietary Aide.

b) Observation of the dining room during a meal identified that several visitors were present in the dining room and interacting with staff and multiple Residents during

meal service for two home areas. Interview with a Registered Nurse confirmed that during outbreak the expectation would be for visitors to visit only with the Resident they came to see, not to be visiting multiple Residents in the dining room area.

c) On a specified date, a Personal Support Worker (PSW) from an affected home area was observed entering a specified dining room during another home area meal service. The Infection Control Practitioner confirmed that staff from the affected home area were not to enter the dining room while meal service for other home areas was in progress.

d) On a specified date, a dietary staff member was observed in a specified dining room washing the surface of the dining room tables with soap and water, and then disinfecting them with Virox wipes prior to the affected home area meal service. However, she did not clean all of the high touch areas (chair arms). The dietary staff member confirmed that not all high touch surfaces were cleaned. The Infection Control Practitioner confirmed that high touch contact surfaces should be cleaned between dining room sittings for all home areas.

e) On a specified date, in a specified dining room, signage was observed that indicated staff were to apply aprons and wash Residents hands. Observation of Resident and staff activity in the dining room revealed that Residents from the affected home area who were escorted to the dining room by staff received aprons, however, no hand hygiene was observed. One Resident entered the dining room from the affected home area during meal service for another home area and sat down, however no one washed the Resident's hands or offered the Resident hand sanitizer. Interview with a Registered Practical Nurse confirmed that the expectation was for staff to assist Residents with washing their hands before they come into the dining room and after they are finished eating.

The Outbreak Management Policy, IPC-K-10, revised July 2013, indicated that additional control measures (hand hygiene) and or additional precautions based on the confirmed or suspected organism will be instituted in the event of suspected or confirmed outbreak.

On March 2, 2015 Long Term Care Home Inspectors were notified by the Infection Control Practitioner that the home was declared in Enteric Outbreak in addition to the Respiratory Outbreak currently in progress.

During the tour of the home on February 26, 2015 by an Inspector the following was

noted:

-in a tub room Wing 3, an unlabeled comb on a vanity, and products on the floor (body wash and shampoo).
-in a tub room Wing 4, it was noted there was a cleaning brush on the floor, debris in the tub, a bar of soap on a moulded ledge in a shower surround, an unlabeled kidney basin, and a toothbrush on a vanity.
-in a tub room, there were unlabeled nail clippers in a drawer.
-during tour of Resident washrooms on February 26, 2015 it was noted there were dirty/dusty bed pans on the toilet tank in four washrooms. It was checked again on February 27, 2015 and no change was noted.
-there were basins on grab bars in nine washrooms.
-there was an unlabeled hair brush noted on a vanity in two washrooms.
-there was an unlabeled bed pan noted on the toilet tank in four washrooms. It was checked again on February 27, 2015 and there was no change in practice noted.
-a bar of soap was noted sitting on a sink in one washroom.

The Inspector spoke to the Infection Control Designate on a specified date regarding their program on wash basin and bed pan storage practices (on grab bars, toilet tanks) and she confirmed that she had discussed this with Public Health re: options for cleaning and disinfecting wash basins, however, no current monitoring was in place to determine if staff follow their Infection Control Policy. [s. 229. (4)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were implemented for cleaning of the home, specifically soiled utility rooms and resident rooms or that procedures were developed specifically for cleaning of heating/cooling incremental units.

A) Housekeeping services in the home was being managed by a contracted service provider. According to the contracted service provider's housekeeping policy HGK F-25-25 titled "Soiled Utilities", staff were required to damp wipe daily all horizontal surfaces. According to various housekeepers, the utility rooms were cleaned weekly as time allowed. All 8 soiled utility rooms were inspected on two specified dates, a day apart, and a drying rack in each of the rooms was observed to be rusty, dusty and full of debris resembling ceiling tile dust.

B) Housekeeping policy ES C-10-05 titled "Detailed Unit Cleaning Procedure" and

policy HKG B-15-35 titled "Staff Daily Cleaning Routines" with an additional area on the form titled "unit cleaning schedule", required housekeeping staff to clean all rooms daily (spot wipe walls, mop floors, change garbage etc.) and to deep clean each room twice monthly by ensuring that areas under beds and furniture be cleaned. Based on observations between February 18 and 27, 2015, it did not appear that rooms were adequately cleaned on a daily basis and/or deep cleaned and further more deep cleaning had been suspended beginning February 23, 2015 due to an outbreak. Some confusion was raised between different housekeepers as to deep cleaning frequency during outbreaks. Housekeeping procedures did not address any change in schedules during outbreaks. Twenty five rooms on designated floors were observed during the tour on February 26, 2015 before 1300 hours to have heavy dust or debris accumulations under the bed (mostly under head of bed). Eight rooms on a designated floor had visible matter on the walls. A random number of rooms were revisited and the visible dust, debris or wall matter seen on a specified date, was still evident in a total of twelve rooms.

C) No specific cleaning instructions or procedures were developed for incremental heating/cooling units cleaning. Policy ES-E-40-30 related to monthly maintenance checks but no cleaning requirements. Incremental units were observed to have stuck on debris on the inside between the louvered cover and the grilles on the interior in but not limited to a specific dining room and seven Resident rooms [s. 87. (2) (a)]

2. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were implemented for cleaning and disinfection of resident care equipment (non-critical devices such as bed pans and wash basins) in accordance with evidence based practices.

According to the home's procedure IPC-C-10 dated March 2014, non- critical devices were to be cleaned followed by disinfection which is in accordance with best practices literature titled "Cleaning, Disinfection and Sterilization of Medical Equipment/Devices, 2013 developed by the Provincial Infectious Diseases Advisory Committee. The licensee's procedures however further described that during outbreaks, more extensive cleaning disinfection would be required and anyone on contact precautions would have their articles cleaned and disinfected in their room. No specific guidelines were provided as to how this would be accomplished. No information was available in the infection control binder regarding the use of the soiled utility room as a processing centre for soiled articles. In the soiled utility rooms however, instructions were posted as to how to clean and disinfect the articles using a cleaner followed by a disinfectant. Drying racks had been set up above the sinks. During the inspection, while the home

was in outbreak, observations that were made led to the conclusion that procedures were not implemented based on the following:

A) Disinfectant was not hooked up to the dispensing system in 5 out of the 8 soiled utility rooms over a 2-day period (February 26-27, 2015). According to the Infection Control Designate (ICD) a cleaning schedule was developed for basin and bed pan cleaning, so that staff would clean designated Resident articles on different nights of the week. The schedule was designed so that each article was cleaned and disinfected only once per week, instead of after each use as identified in the best practices literature.

B) Dusty bed pans and wash basins were stored on dusty and rusty drying racks in 3 utility rooms over a 2-day period. Articles appeared to have been left in the soiled utility rooms without being returned to the Residents after being cleaned and disinfected. After disinfection, according to the ICD, bed pans and wash basins were to be protected from contamination by placing them in a bag. No covered items were seen and all 8 rooms had rusty and dusty drying racks.

C) Dirty/dusty bed pans were on the toilet tank in two washrooms, and on the floor in two washrooms over a 2-day period. A soiled bed pan was found on the toilet tank in a specified Resident washroom.

D) Wash basins were stored inappropriately above the toilet on a grab bar in twelve washrooms. Storage of cleaned and disinfected basins above toilets is considered a "dirty" area as it is exposed to potential contamination from activities around toileting. [s. 87. (2) (b)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are implemented for cleaning of the home, specifically soiled utility rooms and resident rooms or that procedures are developed specifically for cleaning of heating/cooling incremental units, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that:
(a) the documented record (of complaints received) is reviewed and analyzed for trends, at least quarterly
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home, and
(c) a written record is kept of each review and of the improvements made in response.

The Complaints binder was reviewed during Stage 2 of the Resident Quality Inspection (RQI).

Upon interview with the Executive Director (ED), it was confirmed that there has not been a documented record of an analysis for trends completed for complaints that were received in 2014. The ED stated that it is being developed for 2015 and the data is being collected. [s. 101. (3)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following analysis and follow-up actions:
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

There was a complaint issued with the home regarding the wound care provided by a Registered Staff when a dressing was changed on a Resident.

A treatment was used on the wound that had not been ordered by the Physician.

A Critical Incident was submitted to the Ministry of Health and Long Term Care.

It was confirmed with the Assistant Director of Care (ADOC) that the Critical Incident Form submitted to the Ministry of Health was not amended to include the follow up actions with the staff involved in this incident. [s. 104. (1) 4.]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs that were obtained for use in the home, except drugs obtained for any emergency drug supply, were obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time.

Observation of the stock medication room revealed the following:

Sodium Cyclamate 100 mg tablets, 96 bottles
Vitamin B12 injectable 10 000mcg/10ml , 106 bottles
Ferrous Gluconate 300 mg, 96 bottles
Hydrogen Peroxide topical solution 3% H2O2, 41 bottles

On a specified date, in an interview with the Assistant Director of Care (ADOC) responsible for ordering supplies, it was reported that the above supplies were ordered previously as she had only started ordering the stock supplies in November 2014. She confirmed the above stock medication was more than a three month supply and had not been used since November 2014. [s. 124.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs that were stored in an area or a medication cart
complied with manufacturer's instructions for the storage of the drugs.

In a home area medication room, it was observed that there was a bottle of Alugel that had expired December 2014, and a bottle of Senokot tablets sitting on a shelf with the expiry date of November 2014.

On a specified date the following was observed in a stock medication room:
10 bottles of Ferrous Gluconate, expired December 2014.
24 bottles of Potassium Chloride Solution, expired February 2014 and
10 bottles of Chlorhexidine Gluconate, expired October 2014.

The Assistant Director of Care (ADOC) responsible for ordering supplies, confirmed that the above drugs had expired and that the drugs were not stored as per manufacturer's instructions. [s. 129. (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 drugs are stored in an area or a medication cart,
complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting), to be implemented voluntarily.

Issued on this 10 day of June 2015 (A1)

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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Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : BERNADETTE SUSNIK (120) - (A1)

Inspection No. / No de l'inspection : 2015_258519_0010 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : L-001829-15 (A1)

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

Report Date(s) / Date(s) du Rapport : Jun 10, 2015;(A1)

Licensee / Titulaire de permis :
REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR,
MISSISSAUGA, ON, L5R-4B2

LTC Home / Foyer de SLD :
FOREST HEIGHTS
60 WESTHEIGHTS DRIVE, KITCHENER, ON,
N2N-2A8

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Carol Ois

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To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_271532_0029, CO #001;

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 continence assessments are completed for two specific Residents, and other Residents experiencing a change in continence.

Grounds / Motifs :

1. Previously issued as a compliance order on May 8, 2014 following the RQI inspection and reissued August 19, 2014 following a Follow up inspection.

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

A Resident was identified to be continent of bowel and urine at the time of admission.

Minimum Data Set (MDS) review completed identified that the Resident was usually continent of bowel and frequently incontinent of bladder. Interview with the Registered Practical Nurse completing the MDS review on continence, confirmed that the Resident's incontinence was not assessed using a clinically appropriate tool when the Resident was assessed to have a change in continence from continent to frequently incontinent of bladder.

A Resident , who is incontinent, did not receive an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. (192)

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

The Minimum Data Set (MDS) revealed that a Resident was assessed as being frequently incontinent of bladder, tended to be incontinent daily but had some control present, and was usually continent of bowel less than weekly.

The previous Minimum Data Set revealed that the Resident was continent of bowel

and had complete control.

When interviewed the Resident indicated that they do have bowel movements in their brief.

The Assistant Director of Care (ADOC) and record review both confirmed that the Resident did not have a continence assessment completed for bowel when it was triggered in the quarterly assessment.

In an interview the ADOC shared that once the Resident was identified and triggered through the Minimum Data Set (MDS) as being usually continent of bowel from being completely continent there should have been a continence assessment completed.

The ADOC shared that the continence assessment that should have been completed was the Admission/Quarterly Continence Assessment (ON), however, the Admission/Quarterly Continence Assessment (ON) was reviewed for bowel assessment and it was noted that the assessment did not include identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions related to bowels; it was an assessment for bladder only.

The ADOC reported in an interview that the staff were educated on completing the continence assessment annually or quarterly if the Residents were triggered as a change. However, she indicated that she failed to include this as part of the auditing process. When asked if she could show that assessments were being done on Residents who were triggered through MDS, or have a change in status concerning continence, the ADOC confirmed that she could not show the Inspector this information. She confirmed that the focus has been to have these assessments completed for admission as previously that was not getting done.

The ADOC confirmed that there was no continence assessment completed once the Residents were being triggered or experiencing a change in their continence status. (532)

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

Jun 29, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_226192_0010, CO #005;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will ensure that all staff participate in the implementation of the Infection Prevention and Control program as follows:
a) routine hand hygiene practices
b) the cleaning and disinfecting of contact surfaces during an outbreak

Grounds / Motifs :

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

The licensee failed to ensure all staff participate in the implementation of the Infection Prevention and Control program.

The home was declared to be in respiratory outbreak on February 22, 2015.

Four home areas had Residents with symptoms of illness; one had nine Residents, two areas had three Residents each, and the final area had no Residents with symptoms.

Interview with the Infection Prevention and Control Practitioner identified that the home was making every effort to cohort staff and residents to minimize the spread of infection.

Observation on a specified date identified the following concerns:

a) A Dietary Aide who was wearing gloves was observed in a specific dining room picking up dirty dishes and then interacting with the Residents and visitors, including touching the Residents with the gloved hands. No hand hygiene was completed by the Dietary Aide.

b) Observation of the dining room during a meal identified that several visitors were present in the dining room and interacting with staff and multiple Residents during meal service for two home areas. Interview with a Registered Nurse confirmed that during outbreak the expectation would be for visitors to visit only with the Resident they came to see, not to be visiting multiple Residents in the dining room area.

c) On a specified date, a Personal Support Worker (PSW) from an affected home area was observed entering a specified dining room during another home area meal service. The Infection Control Practitioner confirmed that staff from the affected home area were not to enter the dining room while meal service for other home areas was in progress.

d) On a specified date, a dietary staff member was observed in a specified dining room washing the surface of the dining room tables with soap and water, and then disinfecting them with Virox wipes prior to the affected home area meal service. However, she did not clean all of the high touch areas (chair arms). The dietary staff member confirmed that not all high touch surfaces were cleaned. The Infection Control Practitioner confirmed that high touch contact surfaces should be cleaned between dining room sittings for all home areas.

e) On a specified date, in a specified dining room, signage was observed that indicated staff were to apply aprons and wash Residents hands. Observation of Resident and staff activity in the dining room revealed that Residents from the affected home area who were escorted to the dining room by staff received aprons, however, no hand hygiene was observed. One Resident entered the dining room from the affected home area during meal service for another home area and sat

down, however no one washed the Resident's hands or offered the Resident hand sanitizer.
Interview with a Registered Practical Nurse confirmed that the expectation was for staff to assist Residents with washing their hands before they come into the dining room and after they are finished eating.

The Outbreak Management Policy, IPC-K-10, revised July 2013, indicated that additional control measures (hand hygiene) and or additional precautions based on the confirmed or suspected organism will be instituted in the event of suspected or confirmed outbreak.

On March 2, 2015 Long Term Care Home Inspectors were notified by the Infection Control Practitioner that the home was declared in Enteric Outbreak in addition to the Respiratory Outbreak currently in progress.

During the tour of the home on February 26, 2015 by an Inspector the following was noted:

-in a tub room Wing 3, an unlabeled comb on a vanity, and products on the floor (body wash and shampoo).
-in a tub room Wing 4, it was noted there was a cleaning brush on the floor, debris in the tub, a bar of soap on a moulded ledge in a shower surround, an unlabeled kidney basin, and a toothbrush on a vanity.
-in a tub room, there were unlabeled nail clippers in a drawer.
-during tour of Resident washrooms on February 26, 2015 it was noted there were dirty/dusty bed pans on the toilet tank in four washrooms. It was checked again on February 27, 2015 and no change was noted.
-there were basins on grab bars in nine washrooms.
-there was an unlabeled hair brush noted on a vanity in two washrooms.
-there was an unlabeled bed pan noted on the toilet tank in four washrooms. It was checked again on February 27, 2015 and there was no change in practice noted.
-a bar of soap was noted sitting on a sink in one washroom.

The Inspector spoke to the Infection Control Designate on a specified date regarding their program on wash basin and bed pan storage practices (on grab bars, toilet tanks) and she confirmed that she had discussed this with Public Health re: options for cleaning and disinfecting wash basins, however, no current monitoring was in place to determine if staff follow their Infection Control Policy. [s. 229. (4)] (532)

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

On a specified date, during a lunch meal service, a Personal Support Worker (PSW) was observed to clear dishes onto a cart from multiple tables and proceeded to deliver desserts to Residents without hand hygiene.

The Assistant Director of Care (ADOC) responsible for Infection Control confirmed that the expectation was for staff to use hand hygiene in between handling dirty dishes and food served to Residents.

The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program. [s. 229. (4)]
(165)

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

Jun 29, 2015

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

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

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

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

(b) is on at all times;

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

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

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

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

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

Order / Ordre :

The licensee shall 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.

Grounds / Motifs :

1. During Stage One of this Resident Quality Inspection conducted on February 18, 19 and 20, 2015 fourteen of forty Residents interviewed did not have a call bell easily accessible to them.

An audit conducted on February 25, 2015 by three Inspectors identified that on the three home areas audited 41 bed side call bells were found to be inaccessible to the Residents. [s. 17. (1) (a)]
(192)

2. During Stage One observations it was observed that a Resident's call bell was behind the bed and inaccessible to the Resident. This was confirmed at the time by the Resident who stated that it is often unreachable, and staff do not provide the call bell to him/her when in bed.

Further observation a few days later revealed the call bell on the floor next to the Resident's bed.

The home's policy titled, " Resident/Staff Communication and Response System", LTC-K-40, dated August 2012, stated under #2 - The call bell will be accessible to the resident at all times.

(519)

3. A Resident was observed laying in bed between 1000 hours and 1130 hours. The Resident's call bell was observed to be pinned to the top right corner of the bed, hanging down to the floor during this period of observation. At 1047 hours the Resident was offered a beverage, their head was elevated and assistance was provided. The call bell was not repositioned to be accessible by the Resident until 1130 hours when the Resident was turned and the call bell was placed within reach of the Resident.

Interview with a family member present in the room from 1130 hours, confirmed that the call bell is often hanging on the floor or under the bed and would not be accessible to the Resident.

(192)

4. A Resident was observed to have a call bell that was not accessible to the Resident.

A Resident was observed to be laying in bed, the call bell was laying on the floor under the bed, and would not be accessible to the Resident. The housekeeper was observed to wash the floor in the Resident's room. Following this the call bell was again observed to be laying on the floor under the bed.

A Registered Nurse interviewed identified that it is the expectation that the call bell be pinned to the Resident or in proximity to the Resident, so that it could be activated if necessary.

(192)

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

Jun 29, 2015

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee shall complete the following:

A) Make repairs to the flooring surfaces in the following areas so that the floor is smooth, tight-fitting and impervious to moisture;

i) In five designated tub rooms

ii) In a designated bathroom

iii) Floor tiles in a specified Resident bedroom

B) Develop a preventive maintenance program (which includes procedures, inspection schedule and an inspection form) for regular inspections of the flooring, plumbing fixtures (toilets, sinks, drains, taps, mirrors), windows (sills, frames, hardware), furnishings (chairs, wardrobes, vanities, beds), doors (casings, hardware). Document the inspections and develop a schedule to address the identified deficiencies.

C) Prepare and paint all of the surfaces identified in the grounds below. Maintain the walls, doors and casings as per established internal policies and procedures.

The work shall be completed by August 1, 2015.

Grounds / Motifs :

1. As part of the organized program of maintenance services under clause 15 (1) (c)

of the Act, the licensee did not ensure that schedules or procedures were in place for certain preventive maintenance activities.

Maintenance services was being managed by a contracted service provider. According to the Environmental Services Manager (ESM) and the contracted service provider's maintenance policies, no specific procedure was in place to guide maintenance or designated staff in their role in conducting preventive maintenance inspections related to the condition of floors.

A) During the inspection, the flooring conditions below were observed and discussed with the ESM, some of which was known to the ESM and others that were not. No schedule of repair was in place.

i) The flooring material in a tub room was split under the tub, vanity and by the shower entrance.

ii) In a specified bathroom there was an 18 inch long crack at the baseboard/wall junction.

iii) In a tub room the floor was split under head of the tub.

iv) In a tub room, there was a 12 inch crack at the wall/floor junction that was caulked over near the toilet, and a patch of flooring in front of the shower area had one seam split.

v) In a tub room, two cracked areas were noted in the floor in front of the shower surround and when stepped on, water oozed out.

vi) In a tub room, there were 2 long cracks in the flooring on either side of the toilet (wall/floor junction) that were caulked over.

vii) Floor tiles in a bedroom were broken/uneven.

In addition, the maintenance manual did not include any information related to the on-going monitoring of the following:

B) Plumbing Fixtures – No procedure was in place to address the condition of sinks and other components. Rusty sink drains were observed in four washrooms.

C) Windows – No procedure was in place to address the condition of windows and surrounding surfaces such as sills. The laminate on window sills in three rooms was delaminating.
D) Furnishings - Chair frames in many resident rooms were observed to have the finish worn down to an absorbent wood layer. No procedure was in place to manage this issue.
E) Doors – No procedure was in place to address the condition of doors such as the splintered bath doors that were identified in three rooms.

The maintenance manual was reviewed with respect to wall repair and painting services. The maintenance manual was reviewed and confirmation was made that a quarterly schedule and procedure E-75-15 titled "Painting", was in place, however it did not appear that the auditing component and adherence to the schedule was in place. The schedule identified that each floor be painted (touched up) quarterly, however according to the painting log maintained between April 23, 2014 and January 29, 2015, very little actual painting took place. In the time period provided, only 26 rooms had patching and painting completed. The log did not identify whether or not any bathrooms were painted or any doors or casings. The maintenance person in the home who regularly completes the painting reported that the entire home was painted over the summer of 2014 but the work was not identified in the painting log. During the inspection, Inspectors identified numerous areas requiring touch ups, repairs and painting without being able to confirm when they were last painted or repaired.

i) Bathroom door casings were rusted or had paint peeled away around a tub room and fifteen Resident rooms. Bedroom door casings were rusted or had paint peeled away around eleven rooms. A painter was hired the first week of February to paint the bedroom doors and casings, however, the painting was suspended due to an outbreak starting the week of February 23rd, 2015.

ii) Wall damage was evident behind a bed in a specified bedroom, and three specified washrooms. Wall surfaces behind toilets were not remedied when new toilets were installed over the last year. The older model toilets, when removed had old peeling wallpaper or lack of paint behind them in nine bathrooms. [s. 90. (1) (b)] (120)

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

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

Aug 01, 2015

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee shall prepare and submit a plan that summarizes who will assess the lighting levels in the home for compliance with the lighting table and the time frames for compliance following the assessment.

The plan shall be submitted to Bernadette.susnik@ontario.ca by September 1, 2015. The plan shall be fully implemented by December 31, 2016.

Grounds / Motifs :

1. The licensee did not ensure that the lighting requirements set out in the lighting table were maintained.

During Stage One observations it was noted by the Inspectors that some areas of the home had dim lighting.

The home was built prior to 2009 and the section of the lighting table that was applied to determine compliance is titled "All other homes".

A hand held digital light meter was used (Amprobe LM-120) to measure the lux levels in one ward bedroom and one private room, several Resident ensuite washrooms and one corridor. The meter was held a standard 30 inches above the floor and held parallel to the floor. Window coverings were drawn in the Resident bedrooms tested and lights were turned on 5 minutes prior to measuring. Areas that could not be tested due to natural light infiltration were dining rooms and common areas. Outdoor conditions were semi-bright during the measuring procedure.

A) A Resident bedroom was measured on February 27, 2015 and the room was similarly equipped with the same light fixtures as all of the other rooms, whether private or semi-private. Each room had a wall mounted over bed light fixture consisting of fluorescent tubes and a pot light at the entrance to the room. None of the rooms were equipped with bedroom ceiling fixtures. Two different over bed lights were tested and were approximately 330-340 lux. The entrance to room was 157 lux under the pot light with a compact fluorescent bulb. The foot of bed 4 was 188 lux and the side of the bed was 148-150 lux facing the wardrobe. The area between the two beds, at the foot boards, and almost in the centre of the room was between 40-50 lux when both over bed lights were on (both top and bottom bulb). The minimum required lux level for the room in areas where activities of daily living take place such as sitting, dressing or walking is 215.28. The minimum required lux level under the over bed light is 376.73.

B) A Resident bedroom was measured on February 27, 2015 and the lux by the bed side (one side against wall), was 114, the over bed light was 280 lux and at the entrance (pot light with incandescent light bulb) was 105 lux. The minimum required lux level under the over bed light is 376.73 and 215.28 lux in areas of activity.

C) The corridor measured consisted of a drop ceiling, with recessed tube lights along the walls. The lenses over the lights were louvered. Down the centre of the corridor on a specified floor between the tub room and two rooms was 130 lux. The doors were closed to the rooms to eliminate all natural light infiltrating the corridor. The

readings could not be taken down the entire length of the corridor as the windows at the end were large and the blinds could not be drawn. The minimum required lux level for corridors is 215.28 continuous consistent lighting throughout. [s. 18.] (120)

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

Dec 31, 2016

Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee shall complete the following:

1. Clean all drying racks in the soiled utility rooms and attempt to remove the rust.

2. Develop a cleaning schedule that ensures that each utility room is cleaned daily.

3. Develop an audit and audit frequency that will ensure that each utility room is equipped with adequate cleaning supplies and chemicals (disinfectant and soaps).

4. The practice of storing of all personal care articles/devices such as bed pans and wash basins on grab bars, toilet tanks or on the floor shall be discontinued. Alternative arrangements shall be made for the appropriate and clean storage of these devices.

5. Develop procedures that are in keeping with current best practices for staff that details how to clean and disinfect the various types of devices, where and how often and how to store them.

The work shall be completed by May 31, 2015.

Grounds / Motifs :

1. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were implemented for cleaning and disinfection of resident care equipment (non-critical devices such as bed pans and wash basins) in accordance with evidence based practices.

According to the home's procedure IPC-C-10 dated March 2014, non- critical devices were to be cleaned followed by disinfection which is in accordance with best practices literature titled "Cleaning, Disinfection and Sterilization of Medical Equipment/Devices, 2013 developed by the Provincial Infectious Diseases Advisory Committee. The licensee's procedures however further described that during outbreaks, more extensive cleaning disinfection would be required and anyone on contact precautions would have their articles cleaned and disinfected in their room. No specific guidelines were provided as to how this would be accomplished. No

information was available in the infection control binder regarding the use of the soiled utility room as a processing centre for soiled articles. In the soiled utility rooms however, instructions were posted as to how to clean and disinfect the articles using a cleaner followed by a disinfectant. Drying racks had been set up above the sinks. During the inspection, while the home was in outbreak, observations that were made led to the conclusion that procedures were not implemented based on the following:

A) Disinfectant was not hooked up to the dispensing system in 5 out of the 8 soiled utility rooms over a 2-day period (February 26-27, 2015). According to the Infection Control Designate (ICD) a cleaning schedule was developed for basin and bed pan cleaning, so that staff would clean designated Resident articles on different nights of the week. The schedule was designed so that each article was cleaned and disinfected only once per week, instead of after each use as identified in the best practices literature.

B) Dusty bed pans and wash basins were stored on dusty and rusty drying racks in 3 utility rooms over a 2-day period. Articles appeared to have been left in the soiled utility rooms without being returned to the Residents after being cleaned and disinfected. After disinfection, according to the ICD, bed pans and wash basins were to be protected from contamination by placing them in a bag. No covered items were seen and all 8 rooms had rusty and dusty drying racks.

C) Dirty/dusty bed pans were on the toilet tank in two washrooms, and on the floor in two washrooms over a 2-day period. A soiled bed pan was found on the toilet tank in a specified Resident washroom.

D) Wash basins were stored inappropriately above the toilet on a grab bar in twelve washrooms. Storage of cleaned and disinfected basins above toilets is considered a "dirty" area as it is exposed to potential contamination from activities around toileting. [s. 87. (2) (b)] (120)

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

May 31, 2015

Ontario

Ministry of Health and Long-Term Care

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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the height measurement and weight management policy is complied with.

Grounds / Motifs :

1. Where the Act or this regulation required the licensee of the 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 it was complied with.

Previously issued as a Compliance Order regarding the Weight Management policy not being complied with on May 8, 2014 during an RQI.

The home's Height Measurement and Weight Management policy, LTC-G-60 dated June 2014, indicated that each Resident's height would be measured at a minimum annually and each Resident's weight would be taken at a minimum monthly. Residents would be weighed and the weight documented by the 7th day of each month. If a weight loss or gain was 2.0 kilograms or greater from the preceding

month, the weight would be confirmed immediately. The weight record would be reviewed monthly. A nutrition referral to the Registered Dietitian would be completed and the information documented in the progress notes for weight loss or gain of greater than or equal to 5 % of total body weight over one month.

a) A review of Residents clinical health records indicated that 10 of 10 Residents did not have a height taken and recorded annually.

Interview with the home's Registered Dietitian confirmed that annual heights were not completed for each Resident. The Registered Dietitian reported that a process to take Resident's heights on their annual assessments had recently been initiated in January 2015.

b) A review of Resident's clinical health records indicated that 11 Residents reviewed did not have monthly weights taken and recorded.

The home's Registered Dietitian confirmed that the monthly weights were not taken and recorded for the identified months for each of the identified Residents. The Registered Dietitian confirmed that the weights should have been taken and recorded in point click care under the weight tab.

c) A review of a Resident's clinical health record indicated that the Resident experienced a significant weight loss of 10.2% of total body weight over one month, however, there was no referral sent to the home's Registered Dietitian. The Registered Dietitian confirmed that they did not receive a nutrition referral for the Resident's significant weight loss, however, reported that a nutrition referral should have have been completed for the Resident's significant weight loss.

A Resident experienced a weight loss of 3.5 kilograms, however, weight records indicated there was no reweigh taken and documented. This was confirmed by the Registered Dietitian who confirmed that any weight loss or gain of 2.0 kilograms should have a reweigh taken and documented in point click care under the weight tab.

d) A review of a Resident's clinical health record indicated that the Resident experienced a 7 kilogram weight gain, 10.4% of their total body weight. There was no reweigh taken and recorded and no nutrition referral completed, this was confirmed by the Registered Dietitian.

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

The home failed to ensure that Height Measurement and Weight Management policy, LTC-G-60, was complied with. (165)

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

Jun 29, 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

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

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

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 10 day of June 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK - (A1)

Service Area Office /
Bureau régional de services : London