Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 19, 2013	2013_189120_0012	L-000079-13	Complaint

Licensee/Titulaire de permis

GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC
704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3

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

GOLDEN YEARS NURSING HOME
704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 1, 2013

During the course of the inspection, the inspector(s) spoke with the administrator, maintenance staff, non-registered and registered staff.

During the course of the inspection, the inspector(s) toured all home areas, random resident rooms, the dining rooms, linen closets, boiler and storage rooms, took ambient air temperature readings, reviewed policies and procedures related to and reviewed a bed safety audit report.

**The following Inspection Protocols were used during this inspection:
Safe and Secure Home**

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

The licensee of a long-term care home has not ensured that where bed rails are used,

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment

During the inspection, numerous beds throughout the home were noted to have very loose fitting 3/4 length bed rails. Approximately 6 residents were noted to be sleeping on beds with at least one bed rail raised and engaged. The administrator provided documentation that the beds were all tested on September 5, 2012 to determine if any entrapment zones were found. Approximately 98% of the beds failed one or more zones of entrapment related to the bed rail. These zones, if not managed, become areas where bodily parts can become lodged and trapped. The administrator purchased 8 new beds in 2012 and has 12 more on order for 2013. However, the remaining residents who sleep on beds where at last one bed rail is used, remain at risk for injury. Alternatives to reduce the potential risks have not been implemented. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

The licensee of a long-term care home has not developed and implemented a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation services provided to residents of the long-term care home.

The accommodation services, which includes building services is evaluated periodically by management staff for specific maintenance services. Some of the services have established policies and procedures and goals. However, the service as it relates to ensuring residents remain comfortable within the building has not been developed or evaluated. According to Ontario Regulation 79/10, s. 228, no goals, objectives, policies, procedures or a process to identify initiatives for review have been developed.

Staff and family reported that during the week of January 21, 2013, when the outdoor air temperature fell to -27C for several days, the main dining room, activity room and a resident's room were uncomfortably cold. When records were asked to be produced related to the monitoring of indoor air temperatures for the month of January 2013, none could be provided. Policies and procedures related to indoor air temperature monitoring in the winter had not been developed. A series of events leading to uncomfortable conditions were identified during the inspection, all of which were not new to staff or management.

1. Staff reported that windows in resident's rooms and other areas are routinely left open by staff, visitors or residents, regardless of outdoor conditions. During the inspection, a window was left open in room M11 and the outdoor temperature was -13C with the wind chill. The room was uncomfortably cold and occupied by a resident. Windows are also not properly latched after they are closed to seal off any drafts entering around the windows. Four windows in room M12 were left unlatched and one window was partially closed, allowing cold air to flow indoors. Three windows on the lower level were found to be incorrectly closed and air drafts were noticeable. No monitoring occurs regarding these issues.

2. The main dining room on the ground floor has been reported by family and staff as being stuffy or very cold in the winter months. The room is large and is surrounded by windows on two sides of the room. Hot water radiators, located below the windows supply heat to the room. It would appear that the heaters give off heat over their entire length, however they do not. The pipes below the covers do not always match

the length of the covers and certain sections remain cold. Therefore residents sitting near the windows feel a draft from the window and if sitting near a non-heated zone, will feel uncomfortable. The dining room is supplied with fresh air, but only when a person manually flips a switch located in the dining room. The maintenance person reported that the air supply unit does not effectively heat or cool the incoming air. The unit is only capable of heating the air by approximately 20C. If the unit is turned on when outdoor air temperatures are below 10C or above 28C, the inside conditions become uncomfortable, either too hot or too cold. During the inspection, outdoor air temperature was -8C with a windchill of -13C. The dining room fresh air supply was measured with a laser thermometer. Upon initial start up, it measured 7C. Within 15 minutes, it was only capable of warming up to 12.8C. The ambient air temperature began to drop and was 20C a the time of the test. If the fresh air supply were to remain running, the room would not be able to reach and maintain a minimum of 22C. The fresh air supply unit was shut off and the room was allowed to warm up before lunch for resident comfort, however when a tour of the room was made at approx. 12:30 p.m., the air was very stuffy. At approximately 3 p.m., the room reached 22C. The home's temperature gauge located in the room was also the same temperature. The monitoring and use of the fresh air supply unit is not isolated to the maintenance person. The control switch for the unit is located in the dining room and is accessible to all staff. Staff have reported switching the units on or off. The staff members do not all understand how the system works. Some staff forget that they have turned the system or or off, creating unpleasant conditions. Specific rules and persons accountable for the system have not been developed.

3. The fire exit door in the main dining room is directly linked to the outdoors. Although it is insulated and has weather stripping, it is a source of discomfort for residents who sit near the door. Cold air could be felt radiating off the door. A small portable ceramic heater was located near the door but was not turned on by staff.

4. The location of the ambient air temperature gauge in the activity room was noted to be mounted on a post directly under the forced air heating supply grille. In this location, the thermometer displayed a reading of 25C. However, when a thermometer was placed away from the heating supply grilles and towards the windows (set on a table 10 feet from the windows), it recorded a temperature of 20C. The room does not meet the minimum requirement of 22C. A policy or procedure was not available to describe how ambient air temperature must be monitored and where gauges should be located. [s. 84.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (5) The licensee shall ensure that the emergency plans address the following components:
1. Plan activation. O. Reg. 79/10, s. 230 (5).
2. Lines of authority. O. Reg. 79/10, s. 230 (5).
3. Communications plan. O. Reg. 79/10, s. 230 (5).
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

Findings/Faits saillants :

The licensee has not ensured that the emergency plans address the following components:

1. Plan activation. 2. Lines of authority. 3. Communications plan. 4. Specific staff roles and responsibilities

The home's "loss of heat" and "loss of power" emergency plans do not address when the plan needs to be activated, the lines of authority, communications plan and staff roles and responsibilities (by department). [s. 230. (5)]

Issued on this 19th day of February, 2013

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

B. Susnik

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2013_189120_0012
Log No. / Registre no:	L-000079-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 19, 2013
Licensee / Titulaire de permis :	GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC 704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3
LTC Home / Foyer de SLD :	GOLDEN YEARS NURSING HOME 704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	NANCY KAUFFMAN-LAMBERT

To GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure steps are being taken to prevent resident entrapment and other safety issues related to the use of bed rails. The plan shall include at a minimum the following:

1. Identify what immediate interventions have been implemented to date to mitigate risks to residents that use one or more bed rails.
2. Identify what long term measures will be implemented to ensure beds continue to pass all zones of entrapment. Include time lines.
3.Summarize the number of beds that failed and the area or zone that did not pass the entrapment zone test.
4. Identify the strategy that was used to assess residents and their bed systems (outside of the entrapment audit) to determine what interventions are appropriate.
5. The date(s) when nursing staff and personal support workers have been educated about the bed entrapment issues and the available interventions.
6. Include with the plan, a copy of a policy and procedure that relates to on-going bed safety assessments (preventive maintenance for both bed frame, rails and mattress) and resident needs assessment for bed type, mattress type and bed rail use.

The plan shall be submitted to Bernadette Susnik, LTC Homes Inspector, either by mail or e-mail to 119 King St. E., 11th Floor, Hamilton, ON, L8P 4Y7 or Bernadette.susnik@ontario.ca by March 31, 2013.

Note: If an extension of the compliance date is required, please contact the Inspector at least one week before the original compliance date.

Grounds / Motifs :

1. The licensee of a long-term care home has not ensured that where bed rails are used,

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment

During the inspection, numerous beds throughout the home were noted to have very loose fitting 3/4 length bed rails. Approximately 6 residents were noted to be sleeping on beds with at least one bed rail raised and engaged. The administrator provided documentation that the beds were all tested on September 5, 2012 to determine if any entrapment zones were found. Approximately 98% of the beds failed one or more zones of entrapment related to the bed rail. These zones, if not managed, become areas where bodily parts can become lodged and trapped. The administrator purchased 8 new beds in 2012 and has 12 more on order for 2013. However, the remaining residents who sleep on beds where at last one bed rail is used, remain at risk for injury. Alternatives to reduce the risk have not been implemented.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

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

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

Issued on this 19th day of February, 2013

Signature of Inspector / Signature de l'inspecteur : B. Susnik

Name of Inspector / Nom de l'inspecteur : BERNADETTE SUSNIK

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