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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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
May 10, 2016;	2015_201167_0009 (A1)	H-002402-15	Resident Quality Inspection

Licensee/Titulaire de permis

DEEM MANAGEMENT SERVICES LIMITED
2 QUEEN STREET EAST SUITE 1500 TORONTO ON M5C 3G5

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

HAMILTON CONTINUING CARE
125 WENTWORTH STREET SOUTH HAMILTON ON L8N 2Z1

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 Order #004 related to lighting levels in the home has been amended from December 15, 2015 to July 15, 2016.

Issued on this 10 day of May 2016 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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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): May 21, 22, 25, 26, 27, 28, 29, June 2, 3, 2015.

The following inspections were completed during simultaneously with this Resident Quality Inspection;

Follow up inspections: H-000562-14, H-000561-14.

Complaint Inspections: H-000821-14, H-001165-14, H-001328-14, H-001946-15, H-002469-15, H-002518-15, H-002553-15, H-001604-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director of Care (ADOC), Regional Director, Food Services Supervisor (FSS), Registered Dietitian (RD), dietary aides, housekeeping and maintenance staff, personal support worker staff(PSWs), Registered nurses (RNs), Registered Practical Nurses (RPNs), recreation staff, Physiotherapist, identified residents and family members.

The inspectors conducted tours of the home, measured illumination levels, tested stairwell doors, reviewed environmental services policies and procedures and other relevant policies and procedures, reviewed resident health records, and minutes of meetings and audits conducted by the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission and Discharge

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Trust Accounts

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

16 WN(s)
9 VPC(s)
4 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. 19. (4)	CO #001	2014_189120_0019	120

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) 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. 229 (2).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept up to date related to each evaluation under clause (d) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.
It was noted during a review of the annual Quality Improvement Program Evaluations completed for the Infection Control Program at the home in September 2014, that there was no mention of an identified outbreak that took place at the home in July and August of 2014. It was noted and confirmed by the DOC that the identified outbreak occurred over that time period and that residents required treatment. There was no continued monitoring of the outbreak that the residents and staff were experiencing. No evaluation of the management of the outbreak took place. [s. 229. (2) (e)]

2. The licensee failed to ensure that on every shift, symptoms of infection in residents or the possible presence of a communicable disease outbreak were recorded and monitored and that immediate action was taken as required.

i. The home's policy named [Infection Surveillance and Control - INFE-03-1-1, dated April 2013] directed staff on all shifts to record daily on the "24 hour Symptom Surveillance (mandatory) Form" the symptoms that may determine an infection or the possible presence of a communicable disease outbreak. The policy indicated that the "Infection Surveillance Form' is used to track infections on a day to day basis. Completion of the form was to ensure regular follow-up and also helped to identify potential outbreaks.

ii. During observation of residents during this inspection, it was noted that several residents were observed to have symptoms of a potential outbreak.
iii. During interviews with personal support worker staff, they indicated that there were a number of residents on an identified floor that were experiencing the symptoms and a number of staff members were also reported to have experienced symptoms. Staff indicated that this concern was brought up at a staff meeting, but nothing has been done to deal with the problem.
iv. A review of the report/communication binder and any surveillance forms on the identified floor confirmed that there was no recording or tracking of residents and staff who had symptoms.
v. During an interview with the Director of Care, they confirmed that they were aware that a number of residents were experiencing symptoms and that this had been an ongoing problem for some time. The DOC confirmed that the physician and Nurse Practitioner were aware of the issue as well.
The DOC confirmed staff at the home were not completing any surveillance forms or tracking of the symptoms that the staff and residents had been experiencing.
vi. During an interview with the Nurse Practitioner (NP), they confirmed that residents at the home were treated related to an outbreak in 2014. The NP confirmed that there were currently residents experiencing symptoms on an identified floor. The Nurse Practitioner indicated that they had been asked to see some residents who were experiencing new symptoms as well, but were unaware that staff were also complaining that they had symptoms.
vii. A review of the home's Quarterly Infection Control Committee minutes for 2015, confirmed that there was no mention of these symptoms of outbreak in the minutes despite the fact that the symptoms had been an ongoing issues and the home did have prior history of the same symptoms in 2014.
It was noted that there were two complaints logged at the Hamilton Service Area Office related to staff and residents experiencing the identified symptoms. [s. 229. (5) (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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that the home was maintained in a safe condition and in a good sate of repair.

A) Cracked, lifted and missing floor tiles were observed in the basement corridor near the entrance to the kitchen, main staff lounge and common washroom near the laundry room. The tiles were replaced since this issue was identified during an inspection in March 2014, however the underlying problem was not rectified. The concrete under the tiles was not even and was noted to be spalling (breaking up) in the basement corridors.
B) Toilet seats were tested and noted to be loose on May 28 and June 2, 2015 in five identified rooms and a tub room. Inspector #169 noted that the seat in a spa room was loose on an identified date in May 2015. Some were extremely loose and presented an unsafe condition for those residents who use the toilet. Information was relayed to the maintenance person who reported that they were not aware of them as staff had not documented the disrepair in the maintenance log. The maintenance log was reviewed and none of the staff (housekeepers or personal support workers) reported the issue.
C) A scalding hot collator was stored in an office on an identified floor that was accessible to residents. The office door did not have lockable door hardware on it. The issue was reported to registered staff.
D) A latching slide lock was observed on the outside of one of two bathroom doors used by residents in the basement and a utility room on an identified floor. A person using the room or bathroom would not be able to get out of the room if the latch were engaged.
E) Several tripping hazards were identified in the outdoor space from the 1st floor dining room exit door and down to the patio area along a long wooden ramp. The exit area was equipped with a piece of angled wood from the threshold to the top of the wood deck which was not smooth. Two locations along the wooden deck ramp presented with depressed pieces of wood which were not even with the other pieces, creating a lip or area to trip over. [s. 5.]

Additional Required Actions:

CO # - 002 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 the home is a safe environment for its residents related to the outdoor area (ramp), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to stairways were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and was connected to the audio visual enunciator that was connected to the nurses’ station nearest to the door.

The home's multiple stairwell doors were tested on May 28, 2015. Two doors were tested in the basement, three doors on the 1st floor, two doors on the 2nd floor and two doors on the 3rd floor. None of the stairwell doors tested had an alarm located at the door. The 1st and 2nd floor doors were connected to an alarm that sounded at the nurse's station. However, the audio alarm did not indicate the location of the breached door. None of the basement or 3rd floor doors were alarmed in any way. None of the stairwell doors were connected to the enunciator panel closest to that door (at the nurse's station on 1st, 2nd or center of corridor on 3rd) which is required to be equipped with a visual indicator for the location of the breached stairwell door. [s. 9. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with 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. The licensee did not ensure that the lighting requirements set out in the lighting Table to this section were maintained.

The home was built prior to 2009 and therefore the lighting table requirements that applied are titled "All Other Homes". A portable analogue light meter was used to take lighting measurements in various areas of the home. Some areas could not be evaluated due to excessive natural light infiltration. Exterior conditions at the time of the inspection were bright. The light meter was held parallel to the floor and a standard 30 inches above the floor. Only those areas where activity takes place such as walking, eating, reading, dressing, toileting and grooming were measured. The minimum required level of illumination for the areas tested below is 215.28 lux for bedrooms and bathrooms and 215.28 continuous and consistent lux for corridors.

A) In corridors, measurements were taken down the center of the corridor, taking into account the level of light under and between the light fixtures. It was noted that many of the fluorescent ceiling mounted fixtures were flickering, which according to the maintenance person was related to the poor condition of the ballast. In the 1st floor corridor outside of an identified room, the lux was 50, outside of a second identified room, it was 100 and outside of a third identified room, it was 50. The lux near the nurse's station and in front of the bulletin board was 90. The 2nd floor had a lux of 50-125 outside of identified rooms leading up to the elevator. The 3rd floor corridor outside of an identified room, the fixtures were spaced 12 feet apart and the lux levels were 125 and 300 lux directly under two fixtures and 25 lux between them. The basement corridor from the elevator to the kitchen was 50-100 lux, from the dining room to the elevator was 100-150 lux with lights flickering and 25 lux near the laundry room.
B) In resident bathrooms, different types of fixtures were provided, some mounted from the ceiling and some on the wall above the sink area. In three identified washrooms, the level over the sink was 150 lux and the level over the toilet was 50 lux. In another washroom, the lux was 50 over the sink and toilet area. In a third washroom, the lux was 100 at the toilet.
C) In the hair salon, the central room lux was 50-100.
D) In an identified tub/shower room, the lux was 100 at the sink, tub area and in the shower area. One light was burnt out centrally in the room.
E) In the 1st floor lounge, the room was equipped with a ceiling fan with lights and wall mounted lights. The lux was 175 under the fan light. The 2nd floor lounge was similarly equipped with levels 50-100 lux once out and away from the ceiling light fixture.
F) In resident bedrooms, one or more light fixtures were provided, however they were insufficient in providing the required minimum of 215.28 lux throughout the rooms tested. In an identified room, all lights were turned on and allowed to warm up including the over bed lights. The lux directly under the existing ceiling light was 150 and less at the entrance. In an identified room, the light fixture in the center of the room was 100 lux. In an identified room, the lux was 100 at the foot of bed #2 and along the side of bed #1.
G) In the main kitchen, the lux was 50-100 near the dishwasher. Several lights were burnt out and several were flickering. [s. 18.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy named "Falls 09-02-01" was complied with.

The policy directed staff to complete a post falls analysis for residents who were high risk for falls and have had more than three falls in a quarter. Two identified residents were both identified as high risk for falls in their plans of care and a post falls analysis was not completed for either resident. The policy also directed the post falls analysis to be completed by the members of the interdisciplinary team. The form was not completed and it was not interdisciplinary. This was confirmed by the physiotherapist, nursing staff and Director of Care. There was no documentation in the clinical record. [s. 8. (1) (b)]

2. The licensee has failed to ensure that the home’s policy related to RD referrals was complied with.

The home’s policy “Weight Change Program [policy number RESI-05-02-07]", last updated November 2013] directed registered staff to complete a referral to the RD/Dietary Manager for all significant weight changes as outlined in the policy.

Review of resident health record revealed that the referrals were not made to the RD for the following weight changes:
i. Resident #025 experienced a 5.0 percent (%) weight loss over one month in 2015.
ii. Resident #026 experienced a 7.7 % weight loss over one month in 2015.
iii. Resident #027 experienced a 5.4% weight loss over one month in 2015, and continued to lose further weight, resulting in a 10.4% weight loss over a six month period in 2015.
iv. Resident #028 experienced a 7.2% weight loss over one month in 2015.
v. Resident #029 experienced an 8.0% weight loss over one month in 2015.
vi. Resident #030 experienced a 5.2% weight loss over one month in 2015.
vii. Resident #021 experienced an 11.4% weight loss over a six month period in 2015.
vii. Resident #001 experienced a 14.6% weight loss over a six month period in 2015.
Interview with the RD confirmed that dietary referrals for weight changes are consistently not completed, requiring the RD to go through all of the resident’s charts each week on their own to evaluate the weight changes. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff at the home comply with the home's policies related to Falls Management and Referrals to the Dietitian, to be implemented voluntarily.

WN #6: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on at a minimum, interdisciplinary assessment of the following health condition with respect to resident #030: Constipation

i. During a review of the health file for resident #030, it was noted that they had a diagnosis of constipation upon admission in 2014.
ii. A review of the Minimum Data Set Assessments (MDS) for the resident from the time of admission identified that constipation was a health condition that the resident experienced.
iii. During a review of the resident’s progress notes and Medication Administration Records (MARs), it was noted that the resident was regularly taking prescribed medications for constipation. It was also noted that the resident required PRN (as necessary) use of another medication to maintain bowel function. On an identified date in 2015, the Dietitian prescribed Prune juice daily.
iv. A review of the document that the home refers to as the care plan for resident #030, provided by the Assistant Director of Care and confirmed to be the most current care plan did not include identification of the resident’s constipation or interventions to manage or monitor the constipation. The nutritional care plan did not identify constipation as a problem. [s. 26. (3) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on at a minimum, interdisciplinary assessment of the following health condition: Constipation, to be implemented voluntarily.

WN #7: 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 action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented related to resident #030's bowel function and constipation.

i. Resident #030 had a diagnosis of constipation and was routinely and when necessary taking prescribed medications for this problem. On an identified date in 2015 the resident's bowel medications were changed.
ii. It was noted in the Point of Care electronic documentation for resident #030 that there was no area present to document the resident's bowel movements. It was confirmed by the personal support workers and registered staff that there was no "box" related to bowel function present and that staff have been documenting when the resident had a bowel movement on the 24 hour report sheet. It was also noted

that the 24 Hour Report sheet was not a part of the resident's health file.
ii. Staff interviewed confirmed that they had notified the Assistant Director of Care a few weeks prior about the problem with the Point of Care documentation. During an interview with the Director of Care, they confirmed that they were able to correct this problem and that there were some Point of Care Records for residents that were missing this information.
iii. A review of the "24 Hour Report Sheets" over a 26 day period in 2015, revealed the following:
On one identified date, the report sheet indicated that resident #030 had no Bowel Movement (BM) for three days and the resident refused the suppository and was given an oral laxative.
The next day, the report sheet indicated that the resident had no BM for three days and there was no documentation of any further action taken.
During an identified 19 day period of time, there was no documentation about the resident's bowel function at all.
There was no documentation in the progress notes, Point of Care or 24 Hour Report Sheet to indicate how many bowel movements the resident had over the identified 19 day period of time in 2015, or the amount or consistency.
There was no documentation related to whether or not the resident had a bowel movement after administration of prescribed medications or how many days it had been since the last BM.
On an identified date in 2015, the resident had large projectile vomiting at the lunch meal and received clear fluids for the rest of the day.
The next day, the resident had scant liquid emesis. The resident was offered juice but was unable to swallow. The physician visited the resident. The resident was pocketing food in the evening and refused 2000 medications.
The following day, the progress note indicated that staff were awaiting a call back from the physician. The administrator was notified of the resident's condition and the resident was to be transferred to hospital.
A progress note was completed by the RPN on the day of the resident's transfer to hospital, indicated that the RN came to assess the resident and found the resident's abdomen to be distended and slight bowel sounds noted in the upper quadrants.
No documentation on the progress notes was completed by the RN related to their assessment of resident #030 on the identified day.
The progress notes indicated that the hospital informed the home that the resident had been diagnosed with a bowel problem and the resident was receiving treatment.
v. During interviews with nursing staff, they indicated that the resident was having bowel movements during the identified 19 day period of time, but they may not have been documented by staff.

Assessments, reassessments, interventions and the resident's responses to intervention were not documented related to resident #030's bowel function and constipation. [s. 30. (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 any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to intervention are documented, to be implemented voluntarily.

WN #8: 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 Resident #002 and #011 were reassessed at least weekly by a member of the registered nursing staff when they exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

Resident #002 developed an area of skin breakdown on an identified area in November 2014. In December 2014, three weeks later, the area of skin breakdown deteriorated. A wound assessment of the area was completed in November 2014 and then not again until December 2014. This was confirmed by the Skin Care Coordinator and Director of Care/Administrator. The treatment sheets and clinical progress notes also confirmed the weekly reassessments were not completed.

Resident #011 developed an area of skin breakdown in March 2015. On an identified date in April 2015, the wound was reassessed, however the weekly reassessments in between were not completed. The wound was then reassessed in May 2015 but the reassessment indicated that the skin breakdown had increased in size. The following reassessment was not completed. This was confirmed by the Skin Care Coordinator and Director of Care/Administrator. The treatment sheets and clinical progress notes also confirmed the weekly reassessments were not completed. [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 every resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds (iv) is reassessed weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #9: 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,
(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; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a range of continence care products available and accessible to staff at all times, and in sufficient quantities for all required changes.

i. During interviews with personal support worker staff and registered staff, it was confirmed that the laundry staff responsible for distributing the briefs provide an allotment of usually one brief in the appropriate size per shift for each resident requiring the use of briefs. The staff interviewed also confirmed that if more briefs were required, they are required to ask the registered nurse to go to the basement to get a brief for them to use.
ii. During an interview with the laundry staff responsible for distributing the briefs, it was confirmed that they do not provide a back-up supply of briefs for the units.
iii. During a review of the manual provided by the continence product supplier, it was noted that there should be one back-up bag of each size of brief to be stored on the unit for use if required.
iv. It was confirmed during an interview with the Administrator, that a number of briefs had gone missing and to control the problem they no longer have a back-up supply on the units for staff to access. [s. 51. (2) (f)]

2. The licensee failed to ensure that resident #005, who required continence care products had sufficient changes to remain clean, dry and comfortable.

i. During interviews with personal support worker staff and registered staff, it was confirmed that the laundry staff responsible for distributing the briefs provide an allotment of usually one brief in the appropriate size per shift for each resident requiring the use of briefs. The staff interviewed also confirmed that if more briefs were required, they have to ask the registered nurse to go to the basement to get a brief for them to use.
ii. During an interview with the laundry staff responsible for distributing the briefs, it was confirmed that they do not provide a back-up supply of briefs for the units.
iii. It was noted that resident #005 had frequent need of brief changes related to a medication that they were taking and the staff indicated that they never have enough briefs to provide for sufficient changes. It was confirmed that there was no back-up supply of briefs available and accessible for staff. Staff indicated that they are not able to change the resident's brief until they are able to reach the registered nurse who has to leave what they are doing to go to the basement to get a brief.
iv. It was confirmed during an interview with the Administrator, that a number of briefs had gone missing and to control the problem they no longer have a back-up supply on the units for staff to access. [s. 51. (2) (g)]

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 there is a range of continence care products available and accessible to staff at all times, and in sufficient quantities for all required changes and to ensure that residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #10: 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,
(d) addressing incidents of lingering offensive odours. 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 walls, baseboard heaters and various surfaces in the main kitchen.

A) On May 28 and June 2, 2015, a wall in an identified resident's room was heavily soiled and some visible soiling was noted on walls in five identified rooms and the corridor wall on 3rd floor (under fire hose cabinet). The licensee's resident room cleaning frequencies required that these surfaces be spot cleaned on a daily basis.

B) The wall and floor behind the dish wash machine were visibly soiled. The underside of the stainless steel tables on either side of the dish machine had accumulated matter. The licensee's cleaning procedure for the housekeeper scheduled to work the 1800-2200 shift required that the area be cleaned daily. At the time of inspection, it was noted that the identified areas were hard to reach and that staff did not have the appropriate equipment or tools to be able to easily clean the surfaces. [s. 87. (2) (a)]

2. The licensee did not ensure that procedures were implemented for addressing incidents of lingering offensive odours.

On May 28, 2015 lingering and in some cases offensive odours were noted in five identified residents' rooms. The odours were monitored again on May 29 and June 2, 2015, and noted to be the same or slightly improved. In all cases, the odours were related to either resident hygiene issues (lack of bathing) which permeated the resident's bed area or resident behaviour patterns related to elimination (urine left on the washroom floor near the toilet for an extended period of time). Housekeeping staff interviewed reported that a specialized product to control urine odours was available for them to use, but not used daily. Challenges in using the product included a prolonged contact time and ensuring that the washroom remained unoccupied while the product was applied. Personal support workers did not clean any of the urine left on the floor in two identified washrooms on June 2, 2015 when monitored and was left for the housekeeper.

The licensee's procedure titled "Odours" HKLD-05-03-08 dated September 2013 required that odours be identified, eliminated and monitored to determine if the intervention implemented was successful. A monitoring "tool" was included with the procedure for staff to complete when an unacceptable odour was identified which was to be provided to the Administrator for follow-up. Housekeeping staff interviewed revealed that a formal odour process was not followed. [s. 87. (2) (d)]

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 procedures were implemented for cleaning of the home and addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. As part of the organized program of laundry services under clause 15 (1) (b) of the Act, the licensee did not ensure that procedures were implemented to ensure that a sufficient supply of clean linen, face cloths and bath towels were always available in the home for use by residents.

On May 28, 29 and June 2, 2015, the linen closets, resident rooms/washrooms and tub rooms were monitored for linen quantities. Lines were not being stored in resident washrooms, but were picked up by staff prior to use from a central linen closet or from a cart left in each tub/shower room on each floor. On each day, by 1:30 p.m., the number of face cloths and towels dwindled down to zero depending on the floor. On June 2, 2015, after 1:30 p.m. and once the linen cart was loaded with linens to be delivered to the floors, the laundry room was devoid of any towels or face cloths. No supply was available in the laundry room should staff on the various floors require additional quantities before the next delivery. Various staff members when interviewed regarding linen supply reported that they often had to search for linens on other floors during their shift (day or night) because they ran out on their own floor. The licensee's procedure titled "Distribution of Linen" HKLD-06-03-07 dated September 2013 required that the licensee either use a "exchange cart system or a linen top up system". Either system would ensure that there was a continuous supply of linen available to residents or staff throughout each shift. Observations made concluded that laundry staff had to wait for soiled linens to return to laundry in order to have adequate supply to deliver them back to the various floors. The process observed was not in accordance with the licensee's procedure and therefore not implemented. [s. 89. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures were implemented to ensure that a sufficient supply of clean linen, face cloths and bath towels were always available in the home for use by residents, to be implemented voluntarily.

WN #12: 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 under clause 15 (1) (c) of the Act, the licensee did not ensure that schedules and/or procedures were in place (implemented) for the preventive and remedial maintenance of floors, doors, casings, walls and furnishings.

A) The paint on some walls, wood baseboards, bathroom casings, bathroom doors and bedroom doors in resident rooms and common areas was peeled off, making the surfaces rough and difficult to clean.
B) The flooring material in the kitchen was in disrepair, with seams splitting and a large section missing near the hand sink. The flooring material in the 2nd floor shower area was cracked and lifting around the floor drain, allowing water to seep underneath. The flooring material in the 3rd floor shower area was also lifting around the floor drain.
C) The wall behind a section of the dishwasher in the kitchen was not in good condition, with missing wall tiles and covered over with plastic. The wall in an identified resident washroom near the ceiling was cracked or split and the wall had bubbled. The drywall in the bulk head over the shower area on the 2nd floor had a square hole cut out. According to maintenance records, a leak was reported by staff in March 2015 and the maintenance person required access to the area above the shower light. The drywall was not replaced and finished.
D) The wall paper in an identified resident room was ripped and porous, making it difficult to clean. The wall surface under the window was cracked.
E) The cabinet doors in an identified resident bathroom were in poor condition, with exposed particle board. A dresser in in an identified resident room was chipped along the front edge.
F) The frame (casing) around the exit door located in the dried goods storage room in the basement was heavily corroded with a hole to the outside.

A review was completed of the remedial component of the licensee's maintenance program by reviewing the maintenance log on each floor for a period of 6 months. Staff documented the date and location of a variety of maintenance issues, however, the maintenance person did not identify the date the repair was rectified. Staff on the 1st floor identified on May 20, 2015 that a lift did not have functioning brakes and on May 23, 2015 that an activation station for the nurse call system was not working. Neither of these requests had a response from the maintenance person. It was difficult to determine if the repairs had been completed without testing the lift and activation station at the time of inspection. The maintenance person did not follow the licensee's routine remedial maintenance procedure (Titled "Appendix 2") to check the logs daily, write a response for each entry and to date the response.

A review was completed of the preventive component of the licensee's maintenance program by interviewing the maintenance person and reviewing any documents (schedules, check lists, audits) maintained by him or the Administrator. Apart from the routine daily walk-about completed but not all documented by the maintenance person for building systems (ventilation, hot water, fire safety systems), no completed preventive audit checks could be provided for the status on the condition of the interior of the home such as walls, furnishings, doors, floors, lighting, ceilings etc. The licensee's preventive maintenance procedures identified detailed instructions as to the condition expectations for the various surfaces, equipment and furnishings in the home with accompanying schedules (daily, weekly, monthly, yearly), however, the procedures were not implemented. [s. 90. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that schedules and/or procedures are in place for the preventive and remedial maintenance of the interior of the home, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee did not ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

On May 28, 2015, the air conditioning system for the home was turned on and was cooling the corridors on all 3 resident occupied floors. A large supply air grille for the cooled air was located on the wall on one side of the building in a short corridor on all 3 floors. The air temperature was noticeably cooler on the 2nd floor than on the other floors. On May 29, 2015, the air temperatures remained uncomfortably cool on the 2nd floor and the ambient air temperature was therefore measured on each floor using a hygrometer for a 30 minute period. The hygrometer was placed in the same location on all 3 floors (near the nurse's station). The first and third floors were recorded at 23C, however on the 2nd floor the temperature fluctuated between 18 and 20C. The thermostat for the air conditioning system was located on the 3rd floor and was set to 74F or approximately 23C. However, for an unknown reason, the 2nd floor continued to be supplied by much cooler air than the other 2 floors. Staff in the home were not able to verify air temperatures as they were not monitoring them. No ambient air thermometers were located in any part of the home and no records were being kept to ensure that the home was being maintained at a minimum of 22C. [s. 21.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident, (ii) height upon admission and annually thereafter.

The home did not ensure that resident’s heights were taken annually as evidenced by review of the resident’s clinical records. This was confirmed by the registered staff. [s. 68. (2) (e) (ii)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (1) As part of organized programs of housekeeping and maintenance services under clauses 15 (1) (a) and (c) of the Act, every licensee of a long-term care home shall ensure that an organized preventive pest control program using the services of a licensed pest controller is in place at the home, including records indicating the dates of visits and actions taken. O. Reg. 79/10, s. 88 (1).

Findings/Faits saillants :

1. As part of an organized program of housekeeping and maintenance services under clauses 15(1) (a) and (c) of the Act, the licensee did not ensure that an organized preventive pest control program was in place and that immediate action was taken to deal with pests.

An infestation of Phorid flies (drain flies) were noted throughout the home and during the inspection period May 19-June 3, 2015. The breeding ground for the fly was determined to be the kitchen area in the basement, specifically a drain near the dishwasher. A tour of the kitchen was made on May 28, 2015 and over 50 flies noted in and around the dishwasher. The sanitation was not satisfactory and the wall behind the dishwasher and the flooring in the kitchen was in disrepair. The preventive component of the licensee's pest control program appeared to weigh heavily on the services of the licensed pest controller and not on maintenance or sanitation issues. Pest control records were maintained by the licensee and reviewed for service visits on April 10 and May 1, 2015. During both visits, the drain in the kitchen was cleaned and a foam containing insecticide applied. Other routine visits were made and actions documented, however the actions taken did not appear to be successful in controlling the flies and the licensee did not attempt to take other immediate measures. In speaking with the pest control service technician on May 29, 2015, other actions were required in conjunction with the use of insecticides to increase the success rate of control such as repairing the drain, keeping the drain clean and keeping the kitchen dish wash area clean. An integrated and organized preventive pest management program was not apparent (involving maintenance, housekeeping and pest control treatment methods). [s. 88. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that the drug record book is maintained to include information about drugs that are ordered and received in the home. Several medications were ordered from the pharmacy and the drug record book did not reflect the date the drug was received in the home and the signature of the person acknowledging receipt of the drug. The drug record book was reviewed on second floor and the missing signatures were confirmed with the Registered Practical Nurse. The documentation also confirmed the missing information.

Issued on this 10 day of May 2016 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de sions de longue durée

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
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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_201167_0009 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / Registre no. :	H-002402-15 (A1)
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 10, 2016;(A1)
Licensee / Titulaire de permis :	DEEM MANAGEMENT SERVICES LIMITED 2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5
LTC Home / Foyer de SLD :	HAMILTON CONTINUING CARE 125 WENTWORTH STREET SOUTH, HAMILTON, ON, L8N-2Z1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Enesia Malapela

To DEEM MANAGEMENT SERVICES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required.
O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The Licensee shall ensure that on every shift, symptoms indicating the presence of infection in residents are recorded and monitored and that immediate action is taken as required.

Grounds / Motifs :

1. The licensee failed to ensure that on every shift, symptoms of infection in residents or the possible presence of a communicable disease outbreak were recorded and monitored and that immediate action was taken as required.

i. The home's policy named [Infection Surveillance and Control - INFE-03-1-1, dated April 2013] directed staff on all shifts to record daily on the “24 hour Symptom Surveillance (mandatory) Form” the symptoms that may determine an infection or the possible presence of a communicable disease outbreak. The policy indicated that the “Infection Surveillance Form' is used to track infections on a day to day basis. Completion of the form was to ensure regular follow-up and also helped to identify potential outbreaks.
ii. During observation of residents during this inspection, it was noted that several residents were observed to have symptoms of a potential outbreak.

iii. During interviews with personal support worker staff, they indicated that there were a number of residents on an identified floor that were experiencing the symptoms and a number of staff members were also reported to have experienced symptoms. Staff indicated that this concern was brought up at a staff meeting, but nothing has been done to deal with the problem.
iv. A review of the report/communication binder and any surveillance forms on the identified floor confirmed that there was no recording or tracking of residents and staff who had symptoms.
v. During an interview with the Director of Care, they confirmed that they were aware that a number of residents were experiencing symptoms and that this had been an ongoing problem for some time. The DOC confirmed that the physician and Nurse Practitioner were aware of the issue as well.
The DOC confirmed staff at the home were not completing any surveillance forms or tracking of the symptoms that the staff and residents had been experiencing.
vi. During an interview with the Nurse Practitioner (NP), they confirmed that residents at the home were treated related to an outbreak in 2014. The NP confirmed that there were currently residents experiencing symptoms on an identified floor. The Nurse Practitioner indicated that they had been asked to see some residents who were experiencing new symptoms as well, but were unaware that staff were also complaining that they had symptoms.
vii. A review of the home's Quarterly Infection Control Committee minutes for 2015, confirmed that there was no mention of these symptoms of outbreak in the minutes despite the fact that the symptoms had been an ongoing issues and the home did have prior history of the same symptoms in 2014.
It was noted that there were two complaints logged at the Hamilton Service Area Office related to staff and residents experiencing the identified symptoms. (167)

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

Aug 01, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall complete the following:
1. Repair the basement floor so that it is even and smooth before installing new floor tiles. Monitor condition of flooring in basement on a regular basis.
2. Tighten all toilet accessories as identified in the grounds below. Complete an internal audit of all resident toilets to determine which ones will require routine monitoring due to high use and/or attached accessories (grab bars, raised seats etc). Implement the routine auditing of these accessories and assign the monitoring of the accessories to designated staff who will be responsible for reporting the condition to maintenance staff.
3. Re-locate the collator to a location that is not accessible to residents or install a lock on the identified office.
4. Remove the latching slide lock from the basement bathroom door and replace with a lock that can be readily released from the inside by residents and the outside by staff.

Grounds / Motifs :

1. The licensee did not ensure that the home was maintained in a safe condition and in a good sate of repair.

A) Cracked, lifted and missing floor tiles were observed in the basement corridor near the entrance to the kitchen, main staff lounge and common washroom near the laundry room. The tiles were replaced since this issue was identified during an inspection in March 2014, however the underlying problem was not rectified. The concrete under the tiles was not even and was noted to be spalling (breaking up) in the basement corridors.
B) Toilet seats were tested and noted to be loose on May 28 and June 2, 2015 in five identified rooms and a tub room. Inspector #169 noted that the seat in a spa room was loose on an identified date in May 2015. Some were extremely loose and presented an unsafe condition for those residents who use the toilet. Information was relayed to the maintenance person who reported that they were not aware of them as staff had not documented the disrepair in the maintenance log. The maintenance log was reviewed and none of the staff (housekeepers or personal support workers) reported the issue.
C) A scalding hot collator was stored in an office on an identified floor that was accessible to residents. The office door did not have lockable door hardware on it. The issue was reported to registered staff.
D) A latching slide lock was observed on the outside of one of two bathroom doors used by residents in the basement and a utility room on an identified floor. A person using the room or bathroom would not be able to get out of the room if the latch were engaged.
(120)

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

Aug 01, 2015

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2014_189120_0019, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall complete the following:
1. Equip all stairwell doors in the basement and 3rd floor with an audible alarm at each door so that it will sound at the door when it is left open longer than the programmed delay.
2. Equip the stairwell doors located next to or near rooms 201 and 101 with an audible alarm at each door so that it will sound at the door when it is left open longer than the programmed delay.
3. Connect the basement stairwell doors to the enunciator panel on the 1st floor. If the existing enunciator panel cannot accomodate the additional visual signals, consideration should be given to installing an additional panel at the 1st floor nurse's station.
4. Connect the 1st floor stairwell doors to the enunciator panel on the 1st floor.
5. Connect the 2nd floor stairwell doors to the enunciator panel on the 2nd floor.
6. Connect the 3rd floor stairwell doors to the enunciator panel on the 3rd floor.

Grounds / Motifs :

1. The licensee did not ensure that all doors leading to stairways were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and was connected to the audio visual enunciator that was connected to the nurses' station nearest to the door.

The home's multiple stairwell doors were tested on May 28, 2015. Two doors were tested in the basement, three doors on the 1st floor, two doors on the 2nd floor and two doors on the 3rd floor. None of the stairwell doors tested had an alarm located at the door. The 1st and 2nd floor doors were connected to an alarm that sounded at the nurse's station. However, the audio alarm did not indicate the location of the breached door. None of the basement or 3rd floor doors were alarmed in any way. None of the stairwell doors were connected to the enunciator panel closest to that door (at the nurse's station on 1st, 2nd or center of corridor on 3rd) which is required to be equipped with a visual indicator for the location of the breached stairwell door. (120)

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

Sep 15, 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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

The licensee shall complete the following:
1. Complete an audit of all light ballasts in the home to determine which will require replacement and document the findings. Develop a schedule for replacement. To be completed by August 15, 2015.
2. Increase illumination levels to areas of the home as required by the lighting table in the kitchen and corridors as a priority, followed by resident tub rooms, dining rooms, lounges, washrooms, bedrooms and hair salon.

Grounds / Motifs :

(A1)
1. The licensee did not ensure that the lighting requirements set out in the lighting Table to this section were maintained.

The home was built prior to 2009 and therefore the lighting table requirements that applied are titled "All Other Homes". A portable analogue light meter was used to take lighting measurements in various areas of the home. Some areas could not be evaluated due to excessive natural light infiltration. Exterior conditions at the time of the inspection were bright. The light meter was held parallel to the floor and a standard 30 inches above the floor. Only those areas where activity takes place such as walking, eating, reading, dressing, toileting and grooming were measured. The minimum required level of illumination for the areas tested below is 215.28 lux for bedrooms and bathrooms and 215.28 continuous and consistent lux for corridors.

A) In corridors, measurements were taken down the centre of the corridor, taking into account the level of light under and between the light fixtures. It was noted that many of the fluorescent ceiling mounted fixtures were flickering, which according to the maintenance person was related to the poor condition of the ballast. The 1st floor corridor outside room 100 the lux was 50, outside room #111 it was 100 and outside rooms #105 it was 50. The lux near the nurse s station and in front of the bulletin board was 90. The 2nd floor had a lux of 50-125 outside rooms 208 and 207 leading up to the elevator. The 3rd floor corridor outside room 309, the fixtures were spaced 12 feet apart and the lux levels were 125 and 300 lux directly under two fixtures and 25 lux between them. The basement corridor from the elevator to the kitchen was 50-100 lux, from the dining room to the elevator was 100-150 lux with lights flickering and 25 lux near the laundry room.
B) In resident bathrooms, different types of fixtures were provided, some mounted from the ceiling and some on the wall above the sink area. In washrooms #107, 111 and 110, the level over the sink was 150 lux and the level over the toilet was 50 lux. In washroom #106, the lux was 50 over the sink and toilet area. In washroom #307, the lux was 100 at the toilet.
C) In the hair salon, the central room lux was 50-100.
D) In the 2nd floor tub shower room, the lux was 100 at the sink, tub area and in the shower area. One light was burnt out centrally in the room.
E) In the 1st floor lounge the room was equipped with a ceiling fan with lights and wall mounted lights. The lux was 175 under the fan light. The 2nd floor lounge was similarly equipped with levels 50-100 lux once out and away from the ceiling light fixture.
F) In resident bedrooms, one or more light fixtures were provided, however they were insufficient in providing the required minimum of 215.28 lux throughout the rooms tested. In room #307, all lights were turned on and allowed to warm up including the

over bed lights. The lux directly under the existing ceiling light was 150 and less at the entrance. In bedroom #106, the light fixture in the centre of the room was 100 lux. In bedroom #104, the lux was 100 at the foot of bed #2 and along the side of bed #1.
G) In the main kitchen, the lux was 50-100 near the dishwasher. Several lights were burnt out and several were flickering. (120)

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

Jul 15, 2016(A1)

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

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
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 May 2016 (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 : Hamilton