Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jan 28, 2016;	2014_214146_0005 (A2)	H-000257-14	Resident Quality Inspection

Licensee/Titulaire de permis

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

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

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

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

BERNADETTE SUSNIK (120) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance due date for Order #007 regarding lighting levels (s. 18) in the building has been extended from December 31, 2015 to June 1, 2017.

Issued on this 28 day of January 2016 (A2)

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

Original report signed by the inspector.

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

BERNADETTE SUSNIK (120) - (A2)

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): March 5, 6, 7, 10, 11, 12, 13, 14, 2014.

Follow-up inspections H-000214-13, H-000349-13, H-000355-13, H-000081-14, H-000082-14, H-000208-13 and H-000285-13 were completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Care (DOC), Clinical Coordinator, Resident Assessment Instrument (RAI) coordinator, Environmental Manager, registered staff, Personal Support Workers (PSW's), Registered Dietitician (RD), Food Services Manager, Recreation Manager, recreation staff, dietary aides, housekeeping staff, clerical staff, laundry staff, maintenance staff, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed resident and staff interactions, measured lighting levels, observed beds and mattresses, observed dining service, reviewed policies and procedures, reviewed resident health records and complaint log for 2013 and 2014.

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

Family Council

Food Quality

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

- **19 WN(s)**
- **6 VPC(s)**
- **12 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. 134.	CO #003	2013_205129_0001	506
O.Reg 79/10 s. 26. (3)	CO #002	2013_205129_0001	506
O.Reg 79/10 s. 51. (2)	CO #003	2013_105130_0012	528
LTCHA, 2007 s. 6. (4)	CO #002	2013_105130_0012	506
O.Reg 79/10 s. 68. (2)	CO #011	2013_191107_0003	146
O.Reg 79/10 s. 71. (4)	CO #008	2013_191107_0003	536

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not ensure that suspected abuse of a resident, by anyone or neglect of a resident, was immediately reported to the Director.
A) In January 2014, resident #300 reported an allegation of physical abuse to the home. The abuse allegations were not reported to the Director as confirmed by the DOC.
(B) In February 2014, resident #004 reported verbal and physical abuse to the home. The incident was not reported to the Director as confirmed by the DOC.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

The licensee did not ensure that, where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) is complied with.
(A) The dietary services policy 05-03-02A for daily food temperature recording directed dietary staff to take the temperature of foods just before serving and to record them. Random record review and observation revealed that food temperatures were not done on four occasions in a two week period. The dietary aide confirmed that the temperatures were not taken.
(B) The home's Hypoglycemia Protocol indicated that:
for moderate hypoglycemia under 4 millimoles per litre (mmol/L), staff were to orally administer treatment of juice, honey or soda and recheck capillary blood glucose (CBG) in 15 minutes;
if the CBG remains under 4 mmol/L, give another treatment and recheck CBG in 15 minutes;
Once the CBG is at or over 4 mmol/L, give a protein treatment as specified in the protocol and monitor CBG one hour post snack and two hours after next meal.
the hypoglycemia protocol was not complied with for residents #992, #307 and #308.
(C) On two dates in March 2014, milk was noted to be pre-poured for residents up to 45 minutes prior to meal service. According to the home's Policy 05-03-02: Food Preparation/Daily Food Temperature Recording last revised August 2012, milk is to be held at four degrees Celsius or lower.
i. On one day in March 2014 at 0815 hrs, milk temperatures of pre-poured milk in the dining room read seven degrees Celsius.
ii.On another day in March 2014 at 0915 hrs, milk temperatures of pre-poured milk in the dining room read 13 degrees Celsius.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee did not ensure that every resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
(A) The Licensee did not ensure that resident #964 was cared for in a manner consistent with the resident's needs. The resident's choice of bedtime was not respected.
(B) Resident #964, in March 2014, had to wait over an hour to have an elimination need met. The registered staff confirmed that the resident did have to wait for over an hour for assistance and confirmed at times residents do have to wait for care and services.
(C) In March 2014 resident #501 was not supervised as directed by the plan of care which resulted in a fall. The resident was not cared for in a manner consistent with their needs.

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 LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care that set out clear directions to staff and others who provided direct care to the resident.
The licensee did not ensure that there was a written plan of care that set out clear directions to staff and others who provided direct care to the resident.
(A) Resident #211 had a kardex, signage and a care plan which each gave conflicting directions to staff related to a specific intervention.
(B) Resident #044's current care plan and kardex contained directions related to a specific intervention that had been discontinued several months ago.
(C) Resident #400's care plan had conflicting directions to staff related to a specific intervention.

2. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
(A) Resident #922's care plan directed staff to implement a specific intervention after lunch. Staff did not implement the specific intervention. This information was confirmed by the health record, observation, the staff and the SDM.
(B) Resident #400's care plan directed staff to implement a specific intervention. Staff did not implement the specific intervention on the date of observation.This information was confirmed by the PSW's.
(C) Resident #400's care plan directed staff to implement a specific intervention related to continence care. The staff did not implement the intervention.
(D) Resident #044's care plan directed staff to provide identified specific fluids at lunch. The specific diet was not provided.
(E) On March 11, 2014 resident #212 was observed in the dining room at breakfast being fed in a reclined position in residents' wheelchair. A PSW confirmed that the resident is always in this reclined position. The dietary care plan indicated that the resident is to be positioned in an upright position for meals and snacks.
(F) In March 2014 resident #213 was observed in the dining room at breakfast in a reclined position. The dietary care plan indicated that the resident is to be positioned in an upright position for meals and snacks.

Additional Required Actions:

CO # - 004, 012 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee did not ensure that alternatives to restraining the resident were considered.
A)Resident #400 and resident #024 health records do not include alternatives that were trialled prior to the application of a physical device.

2. The Licensee did not ensure that the restraining of a resident by a physical device was ordered or approved by a physician or registered nurse in the extended class.
A) In March 2014 resident #920 and resident #941 were observed to be using a specific intervention which required the order a physician or a registered nurse in the extended class (RN EC). Staff confirmed there was no order and the interventions were used in error.
B) In March 2014 resident #300 and resident #037 were noted to be using a specific intervention which required a physician or RN EC's order. Staff confirmed the order was not obtained.
C) A review of resident #400's health record and observation of the resident revealed that staff were using two interventions since 2011 that both required physician or RN EC orders. No orders were obtained. This information was confirmed by the clinical co-ordinator and the health record.

Additional Required Actions:

CO # - 005 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 2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. 1. The licensee has not assessed all bed systems, where bed rails are used in accordance with prevailing practices to minimize risk to the resident. The management of the home had their bed systems evaluated for entrapment zones in August 2013, at which time over 90% of the beds failed zones 2-4. No action plan was available for review during an inspection conducted in September 2013 and the licensee was ordered to take measures to mitigate risks to residents by December 31, 2013. Upon re-inspection in January 2014, measures taken were not adequate and another order was issued for non-compliance. The licensee hired a representative of a bed and mattress supplier in January 2014 to evaluate bed entrapment zones. A maintenance staff member reported that they accompanied the representative to the resident rooms and that the representative used their hand to test the compression of the mattresses. They did not follow Health Canada guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards" which requires the beds to be measured using a specific weighted tool. The representative suggested that the home replace their mattresses. The audit was documented on a form which was not dated and did not identify which entrapment zones passed or failed. It only identified if the mattress passed or failed. The audit was then used by the management of the home to order and replace all the mattresses in the home. The mattresses were installed on the beds on February 27, 2014. Maintenance staff also installed mattress keepers (to keep the mattress from sliding side to side) and began the installation of a rail cap for their Kimbell beds to ensure they pass zone 4 (at the rail end) and this process was ongoing at the time of inspection. To date, no post-test has been conducted of all of the beds to determine if the new mattresses have eliminated all zones of entrapment. Only several older model beds (Kimbell) were tested by a maintenance person and found to pass all

zones except zone 4 (at the rail end). During the inspection, random beds were tested, one of each type of model available in the home. A specific model identified as Innvacare Carrol CS3, purchased within the last 12 months was tested with a new mattress on the frame. The rail was found to be very loose in one identified resident room. The rotating assist rail on both sides of the bed did not pass zones of entrapment known as 2 and 3 when re-tested during the inspection. The maintenance person was not able to tighten or adjust the rail due to the design of the fitting. Fifteen such beds were identified and management informed. The management of the home contacted the supplier of the beds regarding the loose fittings. The Director of Care was informed immediately to ensure residents using these beds were not at risk for any entrapment.
During the inspection, several Kimbell model bed styles were also identified to have missing rail release latch knobs and could not be used. One such bed in an identified resident room had the side rail in the raised position and could not be lowered by staff. Maintenance staff were aware of the problem but could not replace the knob as the part was no longer being manufactured. An Innvacare Carroll Echo bed was observed in one resident room with very loose rotating assist rails. This bed was easily adjusted and tightened by the maintenance staff when they were informed. Residents have been evaluated to determine need for rail use. Residents who resided in beds where the home was aware of a zone of entrapment had a gap filler in place and clear direction for staff posted at the head of the bed. However, with the newly identified issues during this inspection, some residents
remained at risk of bed entrapment zones. [s. 15. (1) (a)] (120) [s. 15. (1) (a)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 006

WN #7: 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 as set out in the lighting table were maintained.
According to maintenance staff, lighting levels in corridors, tub rooms, dining rooms have not been changed since the last inspection in April 2013. Approximately seven resident rooms received an upgraded lighting fixture.
Light illumination levels were taken of some areas of the home, using a self calibrating Sekonik Handy Lumi light meter, held at waist height with the light source either above the meter or in front of the meter. Outdoor conditions were overcast during the measurements. Areas not measured do not automatically indicate that they are compliant.
*Main floor dining room - one half of the room is lit with large chandelier lights and one half with pot lights. The half with the pot lights was 400-600 lux. The side with the

chandeliers was as follows:
*175 lux above table #2
*100 lux under chandelier above table #1
*100 lux between tables 7 & 5
*190 lux under the chandelier over table #6 and by the window
*50 lux in and around the steam table and cabinets, 40 lux by the juice machine
The minimum required lighting level is 215.28 lux.
*Chapel area has 18 recessed pot lights and the lux directly under the pot lots was 100 lux. The lux in between the lights was 0 lux. The minimum lighting level is 215.28 lux.
*First floor corridors, wings A and B - down the centre, no light fixtures provided, only along the sides of the corridor. Down the centre was 150 lux continuous lighting. When directly under the fluorescent lights, 220 lux.
Second floor corridors, wings C,D,E - 100-150 lux down centre of the corridors and 100-190 along the edges of the corridors. The minimum lighting requirement level is 215.28 continuous consistent lighting.
*All 1st and 2nd floor bedrooms - one hanging light fixture about 10 feet into the room where the ceiling height increases. Directly below this light, 20 lux (round hanging fixture). All of the drapes in room #280 were closed and all of the over bed lights (both top and bottom bulb) were turned on. The lux of the overbed lights were approximately 540. A measurement was taken by standing at the foot of one bed, which was central to the room and the lux was 20. There was no difference whether the over bed light or ceiling light was on or off for general room lighting. No other light fixtures provided in the room. The minimum lighting level is 215.28 lux.
*Shower/tub room A and B - 150 lux over the tub and 50 lux in the shower stall (opaque cover over a pot light which is not recessed)
*Shower/tub room C - two diff light bulbs were provided in the shower stall, one fixture was 250 and the other 100 lux *Shower/tub room D - 50 lux in the shower stall
*Shower/tub room E - 100 lux over toilet area, 170 lux over the tub and 10-20 lux in shower under lights
Tub and shower room minimum lighting requirement is 215.28 lux. [s. 18.]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 007

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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

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 did not ensure that the resident received a skin assessment by a member of the registered nursing staff within 24 hours of admission.
(A) The admission body audit on resident #044's chart was blank, no notes or date or signature. Confirmed by RN that admission assessment was not completed.
(B) No admission skin assessment was completed on resident #306. This information was confirmed by health record and the staff. [s. 50. (2) (a) (i)]

2. The licensee did not ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, (ii) upon any return of the resident from hospital.
(A) There was no skin assessment completed on the resident #044's return from hospital until five days later when multiple wounds were noted. This information was confirmed by registered staff and the health record. [s. 50. (2) (a) (ii)]

3. The licensee did not ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
(A) Resident #004 was noted to have a wound in June 2013. Wound assessments were not consistently completed weekly after that and the wound deteriorated.
(B) Resident # 037 was identified to have a significant pressure ulcer. The weekly wound assessment was conducted only six times in the last thirteen weeks.
(C) Resident #920 was identified to have a significant pressure ulcer. The weekly wound assessment was conducted only six times in the last thirteen weeks.
This information is confirmed by the registered staff and the health records.

Additional Required Actions:

CO # - 008 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 (a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, (i) within 24 hours of the resident's admission and (ii) upon any return of the resident from hospital, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home had a dining and snack service that provided residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
(A) In March 2014 during lunch service, an inspector observed staff feeding resident #309 without the use of the assistive device as directed in the plan of care
(B) In March 2014 during a breakfast service, inspector observed staff attempting to feed resident #500 pureed cereal without the use of the assistive device as directed in the plan of care.

2. The licensee did not ensure that the home has a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1) (10)
(C) On two occasions in March 2014, proper feeding techniques were not used when feeding resident #500.
(D) In March 2014 resident #214 was observed being fed and proper feeding techniques were not used.

3. The licensee did not ensure that, (b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.
(A) Resident #044 was observed to receive a pureed meal at lunch in March 2014. The resident was not offered assistance as per the care plan until 15 minutes later. The care plan indicated that the resident requires encouragement and cueing at meals and feeding if fatigued.
(B) Resident #100 was observed to received a hot meal at lunch in March 2014. The resident sat in front of the untouched plate asleep for 15 minutes before a PSW awakened the resident and provided assistance. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 009 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, 2(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, 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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that their procedures related to cleaning surfaces such as walls were followed or that the procedures were developed to address the accumulations that occur day to day.
The home's cleaning routines for dietary areas such as the kitchen and serveries, allocated only one day per week for wall cleaning and one day a week for sink cleaning. During the inspection, servery walls in the third floor dining room were heavily soiled with visible matter. The kitchen had heavy accumulated matter attached to the sides of both large sinks.
The home's policy #07-02-01 titled "Resident Room Cleaning" required staff to spot clean walls daily. On March 11, 2014, resident rooms 100, 103, 104, 110, 116, 115, 201, 207, 270, 271, 232, 123, 127, 132, 136 and 139 were observed to have visible matter on walls (around and above beds, near bathrooms and along walls separating the room) and closet doors. Rooms 103, 104, 110 and 116 were observed to be soiled on both March 12, 2014 as well.
Walls were soiled in the 1st, 2nd and 3rd floor dining rooms, especially where carts are parked against walls. According to the housekeeping supervisor, walls in dining rooms are cleaned by the housekeepers once per month. Dietary staff do not have wall cleaning as part of their duties other than servery walls. Walls require cleaning as they become soiled and this is not reflected in the home's schedules or procedures. [s. 87. (2) (a)]

2. The licensee did not ensure that procedures were implemented in accordance with prevailing practices for cleaning and disinfection of communal equipment such as shower chairs. The home's policy 05-07-01 titled "Care and Use of Equipment" directed staff to disinfect commode or shower chairs when visibly soiled and to clean once per week. Best practices for infection control has established that communal equipment be cleaned and disinfected between resident use. It was established that staff did not disinfect shower chairs between resident use in tub/shower rooms identified as #124, 151, 224, 251 on March 11 or 12, 2014. Other tub/shower rooms located on the third floor were observed to have a disinfectant spray bottle for this specific purpose. [s. 87. (2) (b)]

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that schedules and procedures were in place for the building interior which includes but is not limited to furnishings, flooring, ceilings, doors, lights, walls and fixtures.
The licensee's preventive maintenance program exists for major equipment such as heating and ventilation systems and schedules and procedures are in place. The maintenance manual identified how to remediate the majority of the home's interior surfaces but did not identify how the surfaces would be maintained in good condition. The procedures described how to repair the various surfaces such as walls but did not identify who will audit the building interior and how often as part a preventive maintenance program. The maintenance staff did not have any building interior audits to determine what interior surfaces and furnishings required repair, painting or replacement. Without the audits, no schedules were developed to address the issues. The surfaces are addressed only when nursing and dietary staff document a problem in the maintenance log. Wall surfaces, bedroom doors, closet doors and door trim were identified to be either damaged, peeling, chipped or scuffed. One maintenance staff member provided a list of 7 rooms which were re-painted or had remedial maintenance since January 1, 2014. During the inspection, the following was observed:
*Wall damage in rooms 366, 277, 139(b), 321, 236
*Paint peeling on walls in rooms 309, 307, 204, 366
*Condition of night tables (worn surfaces) in rooms 270, 271(x2), 232(x2), 239 (x2), 284(x2), 123, 103, 326, 366
*Condition of desk tops (worn surfaces) in rooms 232, 239(x2)
*Bathroom door trim peeled down to metal in rooms 377, 130, 132, 117, 327, 324, 321, 316, 311, 312, 307, 379, 370, 270, 284. The result is a rough surface that cannot be easily cleaned.
*Closet doors not attached to track in rooms 110, 283, 130
*Bedroom doors in poor condition in rooms 207, 284, 228, Tub (251), 136, 270, Tub (124), 139. Door edges are gouged out, leaving splintered surfaces. The maintenance staff attempted to fill the gouges with wood filler. The laminate covering the doors has broken away, leaving behind a rough, splintered edge with exposed wood and particle board.
* The wood handrails on the 1st and 2nd floors located in the corridors have rough surfaces in certain sections. Wood filler was used in the past to try and smooth out the rough areas, however many rough areas still remain. [s. 90. (1) (b)]

Additional Required Actions:

CO # - 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by

Findings/Faits saillants :

1. The licensee did not ensure that the home's admission package of information included, at a minimum, (d) an explanation of the duty under section 24 to make mandatory reports. This information was confirmed by the administrator and review of three residents' admission agreements. [s. 78. (2) (d)]

2. The licensee did not ensure that the home's admission package of information included, at a minimum, (g) notification of the long-term care home’s policy to minimize the restraining of residents and how a copy of the policy can be obtained. This information was confirmed by the administrator and a review of three residents' admission agreements. [s. 78. (2) (g)]

3. The licensee did not ensure that the resident's admission package of information included, at a minimum, (m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs.
This information was confirmed by the administrator and a review of three residents' admission agreements. [s. 78. (2) (m)]

4. The licensee did not ensure that the residents' admission package of information included, at a minimum, (q) an explanation of the protections afforded by section 26, whistle blowing protection related to retaliation.
This information was confirmed by the administrator and the review of three residents' admission agreements. [s. 78. (2) (q)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's admission package of information, to be given to the resident and substitute decision maker when admitted, includes at a minimum, (d)an explanation of the duty under section 24 to make mandatory reports; (g)notification of the home's policy to minimize the restraining of residents; (m)a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations with respect to the supply of drugs; (q)an explanation of the protections afforded by section 26,, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a restraining device was applied according to manufacturer's instructions.
(A) In March 2014 resident #400 was observed by inspectors sitting in a wheelchair in the hallway with a seatbelt applied. The seatbelt was twisted and applied so loosely so a hand could fit between the resident and the belt. The nurse tightened the belt upon notification.
(B) On March 6, 2014 resident #301 and resident #024 were observed to be wearing seatbelts which were loose fitting. Staff confirmed they are aware that the belt should be tightened to the distance of approximately two finger widths. The devices observed were approximately 4-5 inches from the resident's abdomen. [s. 110. (1) 1.]

2. The resident's condition was not reassessed and the effectiveness of the restraining evaluated by a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.
(A) Resident #400 and resident #024 were not reassessed every eight hours by a member of the registered nursing staff while in restraints. Interviews with two registered nursing staff confirmed that they did not evaluate residents every eight hours for the effectiveness of the restraint. This information was also confirmed by the clinical coordinator. [s. 110. (2) 6.]

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 restraints are applied according to manufacturers instructions and that the resident and the need for restraints are re-assessed at least every eight hours,, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in the implementation of their infection prevention and control program, which includes cleaning and disinfection of personal care articles and measures to prevent the transmission of infectious diseases:
(A) In March 2014 during observation of meal service, it was observed that a PSW did not wash hands appropriately. Handwashing is a recognised measure to prevent the transmission of infection.
(B) Also observed in the same dining room a second PSW, serving breakfast and clearing dirty dishes, began slicing a resident's food without washing hands prior to doing this task. Prevailing practice dictates that handwashing should be done between the tasks and between residents.
(C) In March 2014, inspectors observed unlabelled used toothbrushes in shared bathrooms in four rooms . When one of the residents in a shared room was asked which toothbrush was used by the resident, the resident replied all of them.
(D)During a meal observation in March 2014, an inspector observed a staff member who was feeding two residents, lick own fingers to clean them, then continued to assist to feed both residents. No hand hygiene was done as dictated by prevailing practice.
(E)During the same meal service, only two of the six staff members assisting with the lunch service, were observed to have completed hand hygiene when entering the dining room and during the meal service.

(F) Two very dirty (urine and fecal stains) and dusty bed pans were unlabeled and tucked behind a grab bar in two resident washrooms. Urine stained urine measures were observed on the floor or on toilet tanks in several resident washrooms. The washrooms were being shared by several residents. Personal care articles such as bedpans and urine measures are to be stored in a clean manner and cleaned after each use (if labeled) and cleaned and disinfected after each use if unlabeled.
(G) During an observation of a noon medication pass in March 2014, the registered nursing staff did not complete hand hygiene between residents during the medication pass. The registered nursing staff was giving oral medications to residents and instilling eye drops to residents without washing hands or using point of care hand hygiene agents. [s. 229. (4)]

2. The licensee did not provide all staff with access to point of care hand hygiene agents in accordance with prevailing best practices. According to The Provincial Infectious Diseases Advisory Committee "Best Practices for Hand Hygiene in All Health Care Settings, 2010", point of care hand hygiene agents must be made available for staff use prior to and after caring for residents. At the time of inspection, no hand hygiene agents were available to staff in resident's rooms (point of care) on 1st and 2nd floors. Three hand hygiene dispensing stations were identified in each corridor of both 1st and 2nd floors, however these locations are not considered to be at point of care. Staff were also not observed to be using portable or individual hand hygiene agents prior to caring for residents. An assessment has not been conducted to date to determine where best to install hand hygiene agents outside of resident's rooms as part of the home's infection control program. [s. 229. (9)]

3. The licensee did not ensure that each resident admitted to the home was screened for tuberculosis (TB) within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of the screening were available to the licensee.
(A) Resident #044, less than 65 years of age, did not have TB screening initiated until approximately five weeks after admission.
This information was confirmed by staff and the health record. [s. 229. (10) 1.]

Additional Required Actions:

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

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The Licensee did not ensure that resident #021 was bathed by the method of his/her choice.
(A) During an interview with resident #021 the resident indicated that they cannot always choose the method of bathing. The resident's plan of care indicated that the resident was to have tub baths only. The Point of Care documentation for the last month showed resident received a bed bath twice and a shower twice with no indication in the progress notes to explain why the residents preferred method of bathing was not honoured. [s. 33. (1)]

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations in relation to the following: [57(2)]
(A) Review of Residents' Council minutes identified that the Administrator initialled the minutes following review, however there was no written record to indicate that advice related to concerns and recommendations made by the council were responded to in writing within 10 days. The Administrator confirmed that there was no written record. [s. 57. (2)]

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee did not respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations in relation to the following: [60(2)]
(A) Review of Family Council Minutes identified that the Administrator initialled the minutes following review however, there was no written record to indicate that the advice related to concerns or recommendations made by the council were responded to within 10 days. The Administrator confirmed there was no written record. [s. 60. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

**s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).**

Findings/Faits saillants :

1. The food production system did not, at a minimum, provide for, (d) preparation of all menu items according to the planned menu.
(A) In March 2014 at a lunch service, brown rice was on the menu. No brown rice was observed on the steam table in any of the dining rooms. The dietary aide and FSM confirmed that no brown rice was offered or available.
(B) In March 2014, the breakfast menu contained raspberries. No raspberries were available as confirmed by observation and the FSM.
This information was confirmed by dietary staff. [s. 72. (2) (d)]

WN #19: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee did not ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.
The Administrator confirmed that the last satisfaction survey was completed in 2011.
[s. 85. (1)]

Issued on this 28 day of January 2016 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : BERNADETTE SUSNIK (120) - (A2)

Inspection No. / No de l'inspection : 2014_214146_0005 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-000257-14 (A2)

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

Report Date(s) / Date(s) du Rapport : Jan 28, 2016;(A2)

Licensee / Titulaire de permis : HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

LTC Home / Foyer de SLD : HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Rosemary Okimi

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To HERITAGE GREEN NURSING HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee will ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, including reports for residents #300 and #004.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. Previously issued February 2011 as a WN.
(A) In January 2014, resident #300 reported an allegation of physical abuse to the home. The abuse allegations were not reported to the Director as confirmed by the DOC.
(B) In February 2014, resident #004 reported verbal and physical abuse to the home. The incident was not reported to the Director as confirmed by the DOC. (528)

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

Apr 15, 2014

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2013_191107_0003, CO #003;

Pursuant to / Aux termes de :

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the home's policies for hypoglycemia and food temperatures are complied with. The plan is to be submitted to Barb Naykalyk-Hunt by end of business day April 15, 2014 by mail at 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7 or by email to barbara.naykalyk-hunt@ontario.ca.

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

Grounds / Motifs :

1. Previously issued February 2011 as a VPC, March 2012 as a VPC, January 2013 as a Compliance Order (CO), February 2013 and May 2013 as a VPC because compliance date had not passed.

The licensee did not ensure that, where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) is complied with.

(A) The dietary services policy 05-03-02A for daily food temperature recording directed dietary staff to take the temperature of foods just before serving and to record them. Random record review and observation revealed that food temperatures were not done on four occasions in a two week period. The dietary aide confirmed that the temperatures were not taken.

(B) The home's Hypoglycemia Protocol indicated that:

for moderate hypoglycemia under 4 millimoles per litre (mmol/L), staff were to orally administer treatment of juice, honey or soda and recheck capillary blood glucose (CBG) in 15 minutes;

if the CBG remains under 4 mmol/L, give another treatment and recheck CBG in 15 minutes;

Once the CBG is at or over 4 mmol/L, give a protein treatment as specified in the protocol and monitor CBG one hour post snack and two hours after next meal.

The hypoglycemia protocol was not complied with for residents #992, #307 and #308.

(C) On two dates in March 2014, milk was noted to be pre-poured for residents up to 45 minutes prior to meal service. According to the home's Policy 05-03-02: Food Preparation/Daily Food Temperature Recording last revised August 2012, milk is to be held at four degrees Celsius or lower.

i. On one day in March 2014 at 0815 hrs, milk temperatures of pre-poured milk in the dining room read seven degrees Celsius.

ii.On another day in March 2014 at 0915 hrs, milk temperatures of pre-poured milk in the dining room read 13 degrees Celsius. (146)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Apr 30, 2014

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant:

2013_105130_0012, CO #001;
2014_300560_0003, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.

11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that every resident is properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, including residents #964, 501,

Ontario

Ministry of Health and Long-Term Care

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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

Grounds / Motifs :

1. Previously issued August 2011 as a VPC, February 2012 as a WN, February 2013 as a VPC, May 2013 as a CO and January 2014 as a CO.
(A) The Licensee did not ensure that resident #964 was cared for in a manner consistent with the resident's needs. The resident's choice of bedtime was not respected.
(B) Resident #964, in March 2014, had to wait over an hour to have an elimination need met. The registered staff confirmed that the resident did have to wait for over an hour for assistance and confirmed at times residents do have to wait for care and services.
(C) In March 2014 resident #501 was not supervised as directed by the plan of care which resulted in a fall. The resident was not cared for in a manner consistent with their needs. (146)

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

Apr 15, 2014

Order # /
Ordre no : 004

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

Linked to Existing Order /
Lien vers ordre existant:

2013_191107_0003, CO #001;
2013_191107_0003, CO #002;
2013_191107_0003, CO #010;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan, including residents #922, 400, 044, 212 and 213.

Grounds / Motifs :

1. Previously issued February 2011as a CO, March 2012 as a CO and January 2013 as a CO.
The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
(A) Resident #922's care plan directed staff to implement a specific intervention after lunch. Staff did not implement the specific intervention. This information was confirmed by the health record, observation, the staff and the SDM.
(B) Resident #400's care plan directed staff to implement a specific intervention. Staff did not implement the specific intervention on the date of observation.This information was confirmed by the PSW's.
(C) Resident #400's care plan directed staff to implement a specific intervention related to continence care. The staff did not implement the intervention.
(D) Resident #044's care plan directed staff to provide identified specific fluids at lunch. The specific diet was not provided.
(E) On March 11, 2014 resident #212 was observed in the dining room at breakfast being fed in a reclined position in residents' wheelchair. A PSW confirmed that the resident is always in this reclined position. The dietary care plan indicated that the resident is to be positioned in an upright position for meals and snacks.
(F) In March 2014 resident #213 was observed in the dining room at breakfast in a reclined position. The dietary care plan indicated that the resident is to be positioned in an upright position for meals and snacks. (146)

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Apr 15, 2014

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

The licensee shall ensure that all restraints being used in the home are ordered or approved by a physician, registered nurse in the extended class or other person provided for in the regulations.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. Previously issued February 2011 as a VPC.
The Licensee did not ensure that the restraining of a resident by a physical device was ordered or approved by a physician or registered nurse in the extended class.
A) In March 2014 resident #920 and resident #941 were observed to be using a specific intervention which required the order a physician or a registered nurse in the extended class (RN EC). Staff confirmed there was no order and the interventions were used in error.
B) In March 2014 resident #300 and resident #037 were noted to be using a specific intervention which required a physician or RN EC's order. Staff confirmed the order was not obtained.
C) A review of resident #400's health record and observation of the resident revealed that staff were using two interventions since 2011 that both required physician or RN EC orders. No orders were obtained. This information was confirmed by the clinical co-ordinator and the health record. (146)

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

Apr 15, 2014

Order # /
Ordre no : 006

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

Linked to Existing Order /
Lien vers ordre existant:
2013_189120_0085, CO #001;
2013_189120_0085, CO #002;

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 ensure that:
1. All Innvacare Carroll CS3 beds with rotating assist side rails be secured to the bed frames so that they pass zones 2, 3 and 4 when tested with the entrapment test tool.
2. All beds that are missing a side rail latch release knob be repaired or replaced so that the rail can be readily released by either the resident or the worker.
3. All Innvacare Carroll Echo beds be audited for loose rotating assist side rails and loose rails tightened to remain secure.
4. A bed maintenance check and bed safety audit log be developed and completed in accordance with Health Canada Adult Hospital Bed Guidelines and the bed manufacturer's guidelines.
5. All beds are re- tested for entrapment zones 1-4 once all work has been completed (rail caps installed and rails tightened or replaced)

Grounds / Motifs :

1. Previously issued April 2013 as a CO and November 2013 as a CO.
The licensee has not assessed all bed systems, where bed rails are used in accordance with prevailing practices to minimize risk to the resident.
The management of the home had their bed systems evaluated for entrapment zones in August 2013, at which time over 90% of the beds failed zones 2-4. No action plan was available for review during an inspection conducted in September 2013 and the licensee was ordered to take measures to mitigate risks to residents by December 31, 2013. Upon re-inspection in January 2014, measures taken were not adequate and another order was issued for non-compliance.

The licensee hired a representative of a bed and mattress supplier in January 2014 to evaluate bed entrapment zones. A maintenance staff member reported that they accompanied the representative to the resident rooms and that the representative used their hand to test the compression of the mattresses. They did not follow Health Canada guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards" which requires the beds to be measured using a specific weighted tool. The representative suggested that the home replace their mattresses. The audit was documented on a form which was not dated and did not identify which entrapment zones passed or failed. It only identified if the mattress passed or failed. The audit was then used by the management of the home to order and replace all the mattresses in the home. The mattresses were installed on the beds on February 27, 2014. Maintenance staff also installed mattress keepers (to keep the mattress from sliding side to side) and began the installation of a rail cap for their Kimbell beds to ensure they pass zone 4 (at the rail end) and this process was ongoing at the time of inspection.

To date, no post-test has been conducted of all of the beds to determine if the new mattresses have eliminated all zones of entrapment. Only several older model beds (Kimbell) were tested by a maintenance person and found to pass all zones except zone 4 (at the rail end). During the inspection, random beds were tested, one of each type of model available in the home. A specific model identified as Innvacare Carrol CS3, purchased within the last 12 months was tested with a new mattress on the frame. The rail was found to be very loose in one identified resident room. The rotating assist rail on both sides of the bed did not pass zones of entrapment known as 2 and 3 when re-tested during the inspection. The maintenance person was not able to tighten or adjust the rail due to the design of the fitting. Fifteen such beds were identified and management informed. The management of the home contacted the supplier of the beds regarding the loose fittings. The Director of Care was informed immediately to ensure residents using these beds were not at risk for any entrapment.

During the inspection, several Kimbell model bed styles were also identified to have missing rail release latch knobs and could not be used. One such bed in an identified resident room had the side rail in the raised position and could not be lowered by staff. Maintenance staff were aware of the problem but could not replace the knob as the part was no longer being manufactured. An Innvacare Carroll Echo bed was observed in one resident room with very loose rotating assist rails. This bed was easily adjusted and tightened by the maintenance staff when they were informed.

Residents have been evaluated to determine need for rail use. Residents who

resided in beds where the home was aware of a zone of entrapment had a gap filler in place and clear direction for staff posted at the head of the bed. However, with the newly identified issues during this inspection, some residents remained at risk of bed entrapment zones.

(120)

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

Jul 31, 2014(A1)

Order # /
Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.

TABLE

Homes to which the 2009 design manual applies

Location - Lux

Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout

All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout

In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux

All other homes

Location - Lux

Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout

All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout

In all other areas of the home - Minimum levels of 215.28 lux

Each drug cabinet - Minimum levels of 1,076.39 lux

At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux

O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

(A2)
The licensee shall complete and submit a plan which summarizes how the lighting levels in the home will be increased to comply with current legislative requirements. The plan shall identify time lines and person responsible for the initial lighting assessment followed by time lines and person responsible for upgrading the lighting in the building to meet legislative requirements. The plan shall be submitted by May 31, 2014. The plan shall be implemented by June 1, 2017. The plan shall be emailed to Bernadette.susnik@ontario.ca.

Grounds / Motifs :

1. Previously issued April 2013 as a WN.

The licensee did not ensure that the lighting requirements as set out in the lighting table were maintained.
According to maintenance staff, lighting levels in corridors, tub rooms, dining rooms have not been changed since the last inspection in April 2013. Approximately seven resident rooms received an upgraded lighting fixture. Light illumination levels were taken of some areas of the home, using a self calibrating Sekonik Handy Lumi light meter, held at waist height with the light source either above the meter or in front of the meter. Outdoor conditions were overcast during the measurements. Areas not measured do not automatically indicate that they are compliant.

*Main floor dining room - one half of the room is lit with large chandelier lights and one half with pot lights. The half with the pot lights was 400-600 lux. The side with the chandeliers was as follows:
*175 lux above table #2
*100 lux under chandelier above table #1
*100 lux between tables 7 & 5
*190 lux under the chandelier over table #6 and by the window
*50 lux in and around the steam table and cabinets, 40 lux by the juice machine
A number of the bulbs on the chandeliers were burned out. There were two ceiling fans in the room with lights turned off without any way for them to be turned on. The cords were out of reach and no wall switches were connected to the lights. The minimum required lighting level is 215.28 lux.
*Chapel area has 18 recessed pot lights and the lux directly under the pot lots was 100 lux. The lux in between the lights was 0 lux. The minimum lighting level is 215.28 lux.
*First floor corridors, wings A and B - down the centre, no light fixtures provided, only along the sides of the corridor. Down the centre was 150 lux continuous lighting. When directly under the fluorescent lights, 220 lux. Second floor corridors, wings C,D,E - 100-150 lux down centre of the corridors and 100-190 along the edges of the corridors. The minimum lighting requirement level is 215.28 continuous consistent lighting.
*All 1st and 2nd floor bedrooms - one hanging light fixture about 10 feet into the room where the ceiling height increases. Directly below this light, 20 lux (round hanging fixture). All of the drapes in room #280 were closed and all of the over bed lights (both top and bottom bulb) were turned on. The lux of the overbed lights were approximately 540. A measurement was taken by standing at the foot of one bed, which was central to the room and the lux was 20. There was no difference whether the over bed light or ceiling light was on or off for general room lighting. No other light

fixtures provided in the room. The minimum lighting level is 215.28 lux.
*Shower/tub room A and B - 150 lux over the tub and 50 lux in the shower stall (opaque cover over a pot light which is not recessed)
*Shower/tub room C - two diff light bulbs were provided in the shower stall, one fixture was 250 and the other 100 lux
*Shower/tub room D - 50 lux in the shower stall
*Shower/tub room E - 100 lux over toilet area, 170 lux over the tub and 10-20 lux in shower under lights Tub and shower room minimum lighting requirement is 215.28 lux.
(120)

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

Jun 01, 2017(A2)

Order # /
Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents at risk of altered skin integrity or with altered skin integrity receive a skin and/or wound assessment by a member of the registered nursing staff at least weekly.

The plan is to be submitted to Barb Naykalyk-Hunt by end of business day April 15, 2014 by mail at 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7 or by e-mail to barbara.naykalyk-hunt@ontario.ca.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee did not ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
(A) Resident #004 was noted to have a wound in June 2013. Wound assessments were not consistently completed weekly after that and the wound deteriorated.
(B) Resident # 037 was identified to have a significant pressure ulcer. The weekly wound assessment was conducted only six times in the last thirteen weeks.
(C) Resident #920 was identified to have a significant pressure ulcer. The weekly wound assessment was conducted only six times in the last thirteen weeks.
This information is confirmed by the registered staff and the health records.
(146)

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

Apr 30, 2014

Order # /
Ordre no : 009

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

Linked to Existing Order /
Lien vers ordre existant:

2013_191107_0003, CO #009;
2013_191107_0003, CO #005;
2013_191107_0003, CO #006;

Pursuant to / Aux termes de :

Ontario

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall ensure that the dining and snack service includes:

9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, and
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Ontario

Ministry of Health and Long-Term Care

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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

Grounds / Motifs :

1. Previously issued February 2011 as a CO, March 2012 as a CO and January 2013 as a CO.
The licensee did not ensure that the home had a dining and snack service that provided residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible; and did not ensure that proper techniques were used to assist residents with eating. O. Reg. 79/10, s. 73 (1).
(A) In March 2014 during lunch service, an inspector observed staff feeding resident #309 without the use of the assistive device as directed in the plan of care
(B) In March 2014 during a breakfast service, inspector observed staff attempting to feed resident #500 pureed cereal without the use of the assistive device as directed in the plan of care.
(C) On two occasions in March 2014, proper feeding techniques were not used when feeding resident #500.
(D) In March 2014 breakfast was observed. Resident #214 was observed being fed and proper feeding techniques were not used. (536)

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

Apr 15, 2014

Order # /
Ordre no : 010

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

Pursuant to / Aux termes de :

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

(a) cleaning of the home, including,

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

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

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

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

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

(iii) contact surfaces;

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

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

Order / Ordre :

The licensee shall prepare and submit a plan that identifies how the current housekeeping program will address the issue of dirty walls identified throughout the home and how the housekeeping program will continue to ensure that walls are kept in a sanitary condition in the long term. The plan shall be implemented by May 1, 2014.

The plan shall be submitted and implemented by May 1, 2014. The plan shall be emailed to Bernadette.susnik@ontario.ca.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee did not ensure that their procedures related to cleaning surfaces such as walls were followed or that the procedures were developed to address the accumulations that occur day to day.

The home's cleaning routines for dietary areas such as the kitchen and serveries, allocate only one day per week for wall cleaning and one day a week for sink cleaning. During the inspection, servery walls in the 3rd floor dining room were heavily soiled with visible matter. The kitchen had heavy accumulated matter attached to the sides of both large sinks. Walls and other surfaces in food preparation areas are to be maintained in a clean and sanitary condition at all times. The home's policy #07-02-01 titled "Resident Room Cleaning" requires staff to spot clean walls daily. On March 11, 2014, resident rooms 100, 103, 104, 110, 116, 115, 201, 207, 270, 271, 232, 123, 127, 132, 136 and 139 were observed to have visible matter on walls (around and above beds, near bathrooms and along walls separating the room) and closet doors. Rooms 103, 104, 110 and 116 were observed to be soiled on both March 12, 2014 as well. No procedure was provided related to corridor walls which were heavily soiled on the second floor, in and around the fish tank, along handrails and in areas where residents congregate.
Walls were soiled in the 1st, 2nd and 3rd floor dining rooms (especially where carts are parked against walls). According to the housekeeping supervisor, walls in dining rooms are cleaned by the housekeepers once per month. Dietary staff do not have wall cleaning as part of their duties other than servery walls. Walls require cleaning as they become soiled and this is not reflected in the home's schedules or procedures. (120)

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

May 01, 2014

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 011

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

Pursuant to / Aux termes de :

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

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

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

Order / Ordre :

The licensee shall develop a schedule and person responsible for conducting preventive audits of all resident rooms, common areas and bathing areas.
The licensee shall develop preventative procedures in writing for the building interior, specifically furnishings, flooring, walls, doors and hardware, bathroom toilets, closet doors & hardware, vanities, sinks, faucets, fixtures, windows, ceilings, overbed lights, grab bars, hand rails and any other surfaces identified in resident rooms, common areas and bathing areas that are not already being audited and documented. The procedures are to identify the frequency that the surface or building interior will be monitored and by whom, what the expected condition of the surface or building interior is required to be in and how it will be managed when it is found to be in poor condition or not functioning.
The licensee shall develop a schedule and person responsible to address in a timely manner any identified surfaces or building interior that was identified during the audits in poor condition or not functioning.
Compliance date: July 31, 2014

Grounds / Motifs :

1. Previously issued April 2013 as a VPC.

The licensee did not ensure that schedules and procedures were in place for the building interior which includes but is not limited to furnishings, flooring, ceilings, doors, lights, walls and fixtures.
The licensee's preventive maintenance program exists for major equipment such as heating and ventilation systems and schedules and procedures are in place. However, the program is for remediation with respect to the buildings interior surfaces and furnishings. The maintenance manual identified how to remediate the majority of the home's interior surfaces but did not identify how the surfaces would be maintained in good condition. The procedures described how to repair the various surfaces such as walls but did not identify who will audit the building interior and how often as part a preventive maintenance program. The maintenance staff did not have any building interior audits to determine what interior surfaces and furnishings required repair, painting or replacement. Without the audits, no schedules were developed to address the issues. The surfaces are addressed only when nursing and dietary staff document a problem in the maintenance log. Wall surfaces, bedroom doors, closet doors and door trim were identified to be either damaged, peeling, chipped or scuffed. One maintenance staff member provided a list of 7 rooms which were re-painted or had remedial maintenance since January 1, 2014. During the inspection, the following was observed:
*Wall damage in rooms 366, 277, 139(b), 321, 236
*Paint peeling on walls in rooms 309, 307, 204, 366
*Condition of night tables (worn surfaces) in rooms 270, 271(x2), 232(x2), 239 (x2), 284(x2), 123, 103, 326, 366
*Condition of desk tops (worn surfaces) in rooms 232, 239(x2)
*Bathroom door trim peeled down to metal in rooms 377, 130, 132, 117, 327, 324, 321, 316, 311, 312, 307, 379, 370, 270, 284. The result is a rough surface that cannot be easily cleaned.
*Closet doors not attached to track in rooms 110, 283, 130
*Bedroom doors in poor condition in rooms 207, 284, 228, Tub (251), 136, 270, Tub (124), 139. Door edges are gouged out, leaving splintered surfaces. The maintenance staff attempted to fill the gouges with wood filler. The laminate covering the doors has broken away, leaving behind a rough, splintered edge with exposed wood and particle board.
* The wood handrails on the 1st and 2nd floors located in the corridors have rough surfaces in certain sections. Wood filler was used in the past to try and smooth out the rough areas, however many rough areas still remain.
(120)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Jul 31, 2014

Order # /
Ordre no : 012

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

Linked to Existing Order /
Lien vers ordre existant: 2013_205129_0001, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident, including residents #206, 210, 211 and 044.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Grounds / Motifs :

1. Previously issued August 2011 as a VPC, March 2012 as a VPC and February 2013 as a CO.
The licensee did not ensure that there was a written plan of care that set out clear directions to staff and others who provided direct care to the resident.
(A) Resident #211 had a kardex, signage and a care plan which each gave conflicting directions to staff related to a specific intervention.
(B) Resident #044's current care plan and kardex contained directions related to a specific intervention that had been discontinued several months ago.
(C) Resident #400's care plan had conflicting directions to staff related to a specific intervention. (536)

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

Apr 15, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

Issued on this 28 day of January 2016 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK - (A2)

Service Area Office /
Bureau régional de services : Hamilton