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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 16, 2014; Jan 29, 2015	2014_198117_0032	O-001278-14	Resident Quality Inspection

Licensee/Titulaire de permis

1663432 ONTARIO LTD.
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Long-Term Care Home/Foyer de soins de longue durée

MANOIR MAROCHEL
949 MONTREAL ROAD OTTAWA ON K1K 0S6

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

LYNE DUCHESNE (117), ANGELE ALBERT-RITCHIE (545), HUMPHREY JACQUES (599)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 8, 9, 10, 11, 12, 15, 16, 17, 18 and 19, 2014

The following Complaint Inspection was conducted as part of the RQI: log #O-009025-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Nurse, RAI-Coordinator, Programs Manager, Dietary Manager, Environmental Supervisor, Office Manager, a Psycho-geriatric Nurse, a Nursing Consultant, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Care Workers (PSW), two Housekeeping Aides, a Laundry Aide, an Activity aide, the Presidents of the Family and Resident Councils, Residents and Family Members.

The inspector(s) also toured residential and non-residential areas, observed resident care and services; observed resident rooms, common areas and equipment, observed several meal and snack services, reviewed several of the home's policies and procedures, reviewed the home's Admission Information Package, observed a medication pass including medication room, reviewed minutes for Residents' Council and Family Council, reviewed Resident Health Care records, and reviewed staffing schedules.

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
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **5 VPC(s)**
- **1 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
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #901	2014_198117_0032	117

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.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.15 (2) (a) in that the licensee did not ensure that the home, furnishings and equipment are kept clean and sanitary.

On December 12, 2014, Inspector #599 noted a lingering odour of urine, coming from the Roho cushion, on Resident #15's wheelchair.

In an interview on December 12, 2014 the DOC stated there was a process for cleaning Residents' wheelchair and it was done by the night PSW on the night before Residents' bath days. Cushions were sent to the laundry for cleaning. The DOC also stated there was no written documentation to indicate that the cleaning was done.

In an interview on December 12 2014, staff member #S123 informed Inspector #599, that only the cushion covers were washed in the laundry and that the Environmental Supervisor indicated that nursing staff were expected to clean the plastic/Roho cushions.

Inspector #599 together with the DOC inspected the Roho cushion for Resident #015. The DOC agreed and confirmed that there was a strong smell of urine coming from the dirty cushion and the cover. The DOC requested that the registered staff send Resident #015's Roho cushion to the laundry for cleaning. [s. 15. (2) (a)]

2. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 15 (2) (c) in that the licensee did not ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On December 16, 2014, at 09:45, PSW staffs #S112 and #S119 were getting Resident

#019 for his/her tub bath in the west unit tub room. They seated the resident on the tub chair lift. The tub chair lift was activated, and the resident was elevated approximately 3 feet in the air when the tub chair lift suddenly stopped. PSW staff were unable to get the tub chair lift to function again. Inspector #117 was at the west unit nursing station, located in front of the tub room when incident occurred. PSW #S119 came and got Inspector #117 to witness the problem with the west unit tub chair. Resident #019 was anxious but calm that the tub chair had suddenly stopped functioning. Both PSWs stated that they had changed the lift's battery and still the lift was not functioning. The PSWs stayed with Resident #019. They manually lifted the resident out of the tub chair lift and seated the resident in his/her wheelchair.

Inspector #117 went to the home's Administrator and DOC to advise them of the situation and the need to immediately remove the tub chair from use. The home's Environmental Supervisor, clinical nurse and RAI Coordinator came to the west unit tub room. They examined and removed the malfunctioning tub chair from use.

The new tub chair was brought to the unit. Training on its use is currently being organized by the home's DOC and Nursing Consultant.

It is noted that during Stage 1 of the RQI, several residents had reported to Inspectors #545 and #126 that they often could not have a tub bath due to a malfunctioning tub chair in the west unit tub room. During the Stage 1 tour of the home, several staff members had reported to Inspector #599 that the tub chairs, especially in the west unit tub room was occasionally malfunctioning.

On December 11, 2014, Inspector #117 examined the west unit tub chair. The chair's plastic covering was noted to be torn and missing around all of the seat and back edges, exposing the foam underlay. The metal lower frame, especially around the wheels was noted to be rusted. When the tub chair lift mechanism was tested, the chair did elevate, however it would not descend. The battery was turned off, then back on. The lift mechanism was tried, the chair did elevate, and only after 3 tries, did the descent mechanism activate. A tag on the chair indicated that the tub chair had last been inspected by Ontario Medical Supply (OMS) on July 25, 2014. No information related to the malfunctioning tub chair was noted in the home's maintenance logs. It was also noted that south unit tub room chair was examined and noted to be in the same condition as the west tub room chair. However, there was no noted issues with its lift mechanism.

On December 11, 2014, Inspector #117 spoke with the home's Environmental Supervisor

regarding the west tub chair not functioning properly. The Environmental Supervisor stated that PSW staff had been reporting ongoing issues with the tub chair lift mechanism for several months. He stated that most times, it was a battery problem where recharging was required. He indicated that the home's Administrator had ordered two new tub chairs for the home. He showed Inspector #117 that one of these tub chairs had just been delivered that same afternoon. When asked about plans for replacing the west tub room chair, the Environmental Supervisor stated that the Administrator did not want to replace any tub chair until both new chairs were received so that all staff could be trained at once and both chairs installed once the training was completed. He did not have any timelines as to when the second tub chair would be delivered.

On December 15, 2014, Inspector #117 spoke with several staff members PSWs #S112, #S118 and #S117, who all work on the west unit. The PSWs stated that they will test the tub chair prior to giving residents their scheduled tub bath to ensure that the tub chair was working prior to giving residents a bath. If it was not working, the residents were offered either a bed bath or a shower. The staff members stated that the tub chair had been frequently malfunctioning for the past several months and that this issue had been reported to the home's management. On December 15, 2014, Inspector #117 spoke with the home's Administrator regarding the west unit tub chair. He confirmed that new tub chairs had been ordered several weeks ago. One had been delivered to the home on December 11, 2014 and that he did not have a timeline for the delivery of the second tub chair. The Administrator stated that the new tub chairs would only be installed in the tub rooms once both tub chairs were delivered and all staff trained on their use.

On December 16, 2014, at 10:15 am, the home's Program Manager, who acted as liaison with various service providers, confirmed to Inspector #117 that the new tub chairs were ordered on November 24, 2014. One had been delivered on December 11, 2014. There was no timeline as to when the second tub chair was to be delivered. She confirmed that the west unit tub chair was serviced by Barton Medical, a medical equipment vendor, on the following dates:
-March 21 2014: to repair a malfunctioning hand set controller
-July 25, 2014: annual inspection
-October 15, 2014: to assess malfunctioning lift mechanism. No issues identified at that time as per Program Manager.
-All other issues with the malfunctioning lift mechanism were addressed internally. There was not written log documenting the lifts malfunctioning issues. (Compliance Order CO #901 was issued December 16, 2014 during the inspection) [s. 15. (2) (c)]

3. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 15 (2) (c) in that the licensee did not ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

1) It is noted that on December 8, 9 and 10, 2014 that Inspectors # 545 and #126 had observed that the tub chairs in both the west and south tub rooms were in a poor state of repair.

On December 11, 2014, Inspector #117 examined the west and south unit tub chair. The chairs plastic covering was noted to be torn and missing around all of the seat and back edges, exposing the foam underlay. The metal lower frame, especially around the wheels was noted to be rusted. A tag on the chairs indicated that the tub chairs had last been inspected by Ontario Medical Supply (OMS) on July 25, 2014.

On December 11, 2014, Inspector #117 spoke with the home's Environmental Supervisor regarding the poor state of repair for both tubs chairs. The Environmental Supervisor stated that the home's Administrator had ordered two new tub chairs. He showed Inspector #117 that one of these tub chairs had just been delivered that same afternoon. When asked about plans for replacing the west tub room chair, the Environmental Supervisor stated that the Administrator did not want to replace any tub chair until both new chairs were received so that all staff could be trained at once and both chairs installed once the training was completed. He did not have any timelines as to when the second tub chair would be delivered.

On December 15, 2014, Inspector #117 spoke with the home's Administrator regarding the conditions of tub chairs. He confirmed that new tub chairs had been ordered several weeks ago. One had been delivered to the home on December 11, 2014 and that he did not have a timeline for the delivery of the second tub chair. The Administrator stated that the new tub chairs would only be installed in the tub rooms once both tub chairs were delivered and all staff trained on their use.

On December 16, 2014, at 10:15 am, the home's Program Manager, who acts as liaison with various service providers, confirmed to Inspector #117 that the new tub chairs were ordered on November 24, 2014. One had been delivered on December 11, 2014. There was no timeline as to when the second tub chair is to be delivered.

It is noted that the west unit tub chair was replaced on December 16, 2014 (see

Compliance Order CO #901).

2) On December 10 and 11, 2014, it was observed by Inspector #117 that several residents' bedside tables were in poor condition. In resident room 133-2, Inspector #126 noted on December 9, 2014, that the top part of the night table at Resident #003's bed side was damaged. On December 10, 2014, Inspector #117 noted that in resident room #130, Residents #001 and #002's bedside tables' surfaces were noted to be chipped and have broken laminate surfaces.

On December 15, 2014, Inspector #117 observed the bedside tables in all of the resident rooms, and 25 /64 bed side tables where noted to be in a poor state of repair. The laminate top of the bedside tables were observed to be heavily scared, chipped, with large broken pieces on the top surface and along the edges, exposing the rough underlay. Several of the tops were pitted and warped, with the edges lifting and easily breaking away. Housekeeping staff member #S115 stated that surfaces of the bedside tables are difficult to clean due to broken, chipped and warped surfaces.

On December 15, 2014, Inspector #117 spoke with the home's Environmental Supervisor regarding the poor condition of resident bedside tables. The Environmental Supervisor stated that most bedside tables in the home are original to when the home opened 12 years ago. He reports that several table surfaces were replaced a few years ago but that no action has since been taken to address this issue and that to his knowledge there was no plan to refurbish or replace the tables.

Inspector #117 also spoke with the home's Administrator, DOC and Nursing Consultant regarding the poor state of repair of the resident's bedside tables. The Administrator reported not being aware of the bedside tables' poor condition. The Administrator confirmed that there is no current plan to refurbish or replace the tables. [s. 15. (2) (c)]

3) On December 12, 2014, Inspector #545 observed both beds in room #120 (South Wing). A metal tube approximately 6 to 8 inches in length and 2 inches in diameter, with an opening exposing sharp edges attached to the outside at the foot of the bed and on the side where both residents enter and exit the bed. Near the entrance of the room, two full bed rails were observed, wedged between a dresser and a wall.

On December 12, 2014, when asked PSW #S110 indicated that the metal tube was used

to insert a full bed rail; added that it should have been removed when the bed rail was removed. The PSW indicated that he didn't know when the bed rail was removed, but thought that it might have been removed when the family had brought a bed helper to assist Resident #012 to get in and out of the bed.

On December 15, 2014 during an observation of both beds in room #120, the Director of Care and the Administrator indicated that they were surprised to see this metal tube with sharp edges still in place on these beds. They indicated that the purpose of the metal tube was to insert a full bed rail and to maintain it in place and that it should have been removed at the same time as the bed rail to prevent injury to the residents. The DOC indicated that she would have the Environmental Supervisor review all resident beds immediately to ensure no other beds had metal tubes with sharp edges were left attached to resident beds and posing risk of injury to residents.

On December 16, 2014, the Environmental Supervisor indicated to the inspector that he had not received a request to remove the full bed rail on these beds and that he was not aware that they had been removed. He indicated that he had removed the metal tubes on both beds in room #120. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, such as the removal of all potentially unsafe metal objects attached to residents' beds, repair or replacement of the 25 residents' bedside tables and replacement of the south unit tub chair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (a) (c) in that the licensee did not ensure that there is a written plan of care for each resident that sets out the planned care for the resident; and clear directions to staff and others who provide direct care to the resident.

1) Resident #007 was admitted to the home in January 2012 with a history of chronic urinary tract infections (UTI) and other medical conditions. In July 2013, the Resident was seen in Emergency, was diagnosed with a UTI and returned to the home with a temporary indwelling catheter. The catheter has been in-situ since that date.

Several of the Home's Urinary Catheterization Policies were reviewed by the Inspectors. In the CLIN-07-01-03 Policy (December 2002) it was documented on page 1 of 1 that "A Physician's Order must be received for the type and size of catheter and the frequency of catheterization or length of use between changes". In the Urinary Catheterization: Care Planning Process Policy: CLIN-07-01-04 Policy (December 2002), on page 4 of 6, it was documented that "Laboratory tests such as Urinalysis, Culture and Sensitivity (C&S) of urine were conducted according to the physician's orders". And on page 6 of 6, it was documented that registered staff were to include in the progress notes: insertion, removal

and/or changes of catheters, including:
-Amount, colour and consistency of urine
-Difficulties encountered
-Effect on Resident
-Specimen obtained
-Type and size of catheter, inflation of catheter balloon (including amount of solution used) and attachment of the drainage system

On December 10, 2014, during an interview with Resident #007, a lingering odor of urine was observed in Resident's shared room and bathroom. A catheter leg bag was observed on the Resident's right upper leg, and the resident indicated he/she could not remember when the catheter was last changed, but that it was a long time ago.

In a review of Resident #007's Plan of Care, dated November 2014, it was documented that the Resident had an indwelling catheter related to urinary retention and a catheter change (size 14FR) was required every month to ensure that the Resident remained infection free. Other interventions included: sending a sample of urine to the lab each month during the catheter change for analysis due to a history of UTI. No specific time frame was indicated.

In a review of the progress notes for a period of four months, between September and December 2014 it was documented that Resident #007's indwelling catheter was changed on specified days in September, October, and December 2014. There was no documentation found to indicate a change of catheter for the month of November 2014. The size of the catheter was documented for only one of those dates: size 16 FR (October 2014), which was different from the plan of care where it was indicated to use a size 14FR. A note indicated that a urine sample was captured and sent to the lab for analysis was noted on specified dates in September and October 2014. A note indicated that Resident #007 was treated for a UTI in October 2014.

On December 15, 2014, during an interview with RPN #S108, he indicated that he had changed Resident #007's catheter earlier in the day as per a note in the home's Agenda. The RPN indicated he had difficulty changing the catheter. On that same day, Resident #007 was observed in his/her wheelchair by the nursing station, thanking RN #S121 for re-inserting his/her catheter. RN #S121 indicated to the inspector that Resident #007's catheter had to be removed and a new catheter re-inserted as it was not draining properly; added that due to the Resident's anxiety and rigidity in his/her legs, some nurses had difficulty changing the catheter.

Upon review of the home's Agenda for a period of four months a monthly reminder to change Resident #007's catheter was entered on five specific dates in 2014: September, October, November, December (the note was crossed out) and then 7 days later in December.

In a review of the progress notes, it was documented that Resident #007 had complained of pain on the day before the December catheter changer. The note indicated that Resident #007 complained of pain while voiding and the RPN on duty told the Resident that the indwelling catheter would be changed the following day. According to the progress notes, the last documented catheter change was on a specific day in October 2014, 66 days ago.

During an interview with RPN #S114 on December 17, 2014 he indicated that Resident #007 has an order for an analgesic medication for pain management but that the Resident rarely requested it. RPN #S114 indicated that the Resident informed him of pain on voiding at the end of his shift on three days ago. He indicated that he did not complete a pain assessment when Resident #007 complained of pain; added that he did not offer any interventions except to inform the Resident that the indwelling catheter would be changed the following day. RPN #S114 later indicated to the inspector that when he realized that Resident #007's catheter had not been changed on specific day in December 2014, according to a note in the home's agenda, he crossed out the instruction to change Resident #007's catheter for that identified day and added a note to remind the nurse working the next day to change the Resident's catheter. RPN #S114 indicated that nurses had been using a catheter size 16FR for some time as the size 14FR was leaking. The RPN indicated that he was not aware that the plan of care directed staff to use a size 14FR catheter. He indicated that the plan of care should have been updated.

During an interview with the Clinical Nurse #S102 on December 18, 2014 she indicated that it was the responsibility of the registered staff to check the home's Agenda on a daily basis for any treatment scheduled for the day, including catheter change. She indicated that registered staff were expected to document in the Progress Notes the monthly catheter change in the Resident's electronic chart and include specific details such as: size of catheter used, amount of sterile water used to inflate the balloon, description of urine output upon insertion, how the procedure was tolerated and indicate if urine was sent to the lab. The Clinical Nurse further indicated she was unable to locate the following documentation in Resident #007's health record: a physician order for the

monthly catheter change, a physician order of the monthly urine analysis, a note indicating the catheter change for the month of November 2014, the lab results for urine analysis for the months of November and December 2014.

During an interview with the Director of Care on December 19, 2014 she indicated that registered staff were expected to change Resident #007's catheter on a monthly basis as well as send urine for analysis due to a history of UTI. The DOC indicated that she was not aware that there were no physician orders for these monthly treatments and that staff were not documenting the catheter change as per the home's Indwelling Catheterization policy. She indicated that the Resident's written plan of care did not set out the planned care for the resident; and that there was no clear directions to registered nursing staff and others who provided indwelling catheter care direct care to Resident #007. [s. 6. (1)]

2) Resident #011 was noted to have a urinary catheter. A review of the Resident's health care record showed that the resident had a catheter in-situ at the time of his/her admission in December 2012. Unit RPN #S107 stated that Resident#011's foley was changed every month and that a urine C&S specimen was also collected and tested every month as the resident was identified as being at risk of urinary tract infections.

A review of the Resident #011's health care record was conducted by Inspector #117. The resident's current plan of care noted that Resident #011 had a 16FR catheter which was to be changed every month. Progress notes documented that the resident's catheter was an 18FR that was changed on specific days in December 2014 and October 2014. No information was found in the resident's chart as to whether the resident's catheter was changed in November 2014. A further review of the resident's chart noted that there was no information related to the resident's catheter being changed in July 2014.

On December 19, 2014, the resident's chart was reviewed with the unit RPN #S107. She could not find any medical order or medical directive for the monthly urinary catheter change. There was no information in the chart as to whether the urinary catheter should be a size 16FR (as per resident plan of care) or a size 18FR (as indicated in the progress notes). The Clinical Nurse and RPN #S107 could not confirm if Resident #011 catheter was changed or not for the months of November and July 2014 as there was no documentation in the progress notes or elsewhere indicating if and when the catheter was changed.

Urine C&S reports were found to be done on a monthly basis. Lab results showed that all collected specimens were contaminated and no follow up action related to this was found in the resident's chart. On a specific day in September 2014 lab results documented that the sample collected was positive for three organisms. There was no information in the resident's chart as to, if the resident was presenting with any other signs or symptoms of infection. There is no note indicating that staff contacted the attending physician with the laboratory results or if any other action was taken. As per the RPN #S107, the lab results were kept in the physician's file for review upon his/her weekly rounds. No further action was taken by nursing staff related to urine lab results. The RPN stated that it was the home's practice to take monthly urine samples for all residents with urinary catheters and was not aware if there were any directives in Resident #011's plan of care as it relates to urine testing. This information was confirmed with the home's Clinical Nurse. The Clinical Nurse indicated that it was the responsibility of the registered staff to check the home's Agenda on a daily basis for any treatment scheduled for the day, including catheter change and collection of urine. The Clinical Nurse was not aware of any directives in the resident's plan of care for the monthly collection and testing of the resident's urine, and that the home did not have formal process for follow-up to the urine lab results.

The written plan of care did not set out the planned care and did not give clear directions to registered nursing staff and others who provide direct care to the resident in regards to size of Resident #011's indwelling catheter, changing of the catheter, the collection of monthly urine tests and follow up actions to tests results. [s. 6. (1)]

2. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (7) in that the licensee did not ensure that the care set out in the plan of care is provided to the resident.

Resident #012 has a stage III ulcer to a toe.

During an interview with PSW #S110 on December 12, 2014, he indicated that Resident #012 refuses to wear shoes and has always walked barefoot in the home, added that staff have made many attempts to encourage him/her to wear shoes when ambulating with his/her walker in the home. PSW #S110 indicated to the inspector that Resident #012 has a sore on an identified foot and that he believes that the nurses change the dressing daily, however he has noticed that the dressing was not always changed after Resident received a bath and that the dressing was left wet.

A review of Resident #012's health records indicated that a Stage II ulcer to an identified toe was diagnosed in May 2014 and progressed to a Stage III in November 2014. The medical orders indicated four treatment changes between May 2014 and November 2014:
• May 2014: clean open lesion to toe with normal saline, apply a specific dressing treatment, change every 2 to 3 days and PRN
• June 2014: treatment changed to Proviodine application
• July 2014: cleanse with sterile H2O, apply new dressing treatment and change every 3 days and PRN
• November 2014: cleanse with sterile H2O, apply new more complex dressing treatment and change every 3 days and PRN

Upon review of the most recent plan of care (December 2014), it was documented that Resident #012 had an ulcer to the toe and interventions included to monitor signs and symptoms of infection and to apply Proviodine twice daily and to document.

During an interview with RPN #S108 on December 15, 2014 he indicated that he changed the dressing today as it required it, added that he only changed it when it was required. He indicated that he applied the dressing treatment as per the July 2014 physician's order. When RPN reviewed the doctor's orders in presence of the inspector, he indicated that he was not aware of the change in dressing done 21 days prior, in November 2014, therefore he had not applied the new more complex dressing treatment. RPN #S108 reviewed with the inspector the Treatment Administration Record for Resident #012, and indicated that he followed the directives that were highlighted in orange which was the July 2014 dressing treatment order. When asked who was responsible to updating the plan of care, he indicated that he had received training in the use of the electronic plan of care two weeks ago, however had not yet made any changes in Resident #012's plan of care.

During an interview with RPN #S114 on December 19, 2014 he indicated that on the specified day in November 2014, Resident #012 had returned from an appointment with the specialist with new treatment plan and that he immediately verified the order with the home's physician then transcribed the new more complex treatment plan of November 2014 onto the home's physician order. He indicated that the new treatment plan was transcribed to the Treatment Administration Record on the next day in November 2014. RPN #S114 indicated that he changed the dressing and applied the new more complex dressing treatment to the Stage III ulcer each time he assessed the wound on the

following dates when the treatment was changed:
• The day after the resident's appointment in November 2014,
• 8 days later in December 2014
• 6 days after the above dressing change in December
• 3 days after the second December dressing change

A review of Resident's health care record was done for the period of 22 days, between specified days in November and December 2014, and a description of the type of dressing done to the stage III ulcer of the identified toe of Resident #012 was not found in the home's following documentation for this resident:
• Treatment Administration Record (TAR) with the completed Weekly Skin Assessments
• Medication Administration Record (MAR)
• Progress Notes

RPN #S114 indicated to the inspector that he was instructed to document the weekly assessments using the Weekly Skin Assessment form (Évaluation de Plaie). RPN #S114 indicated that he should have been documenting treatment plan each time he changed the dressing, however had understood that by documenting the weekly assessment of the wound it was understood that the dressing had been changed.

During an interview with the Director of Care on December 19, 2014 she indicated that staff was expected to ensure that Resident #012 who had a stage III ulcer received immediate treatment as prescribed by the specialist, document the dressing change in the progress notes as well as in the Medication Administration Record. [s. 6. (7)]

3. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (9) in that the licensee did not ensure that the following was documented: the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care.

1) On December 9 and December 16, 2014, Inspector #545 observed Resident #004 with an indwelling catheter.

During an interview with Resident #004 on December 18, 2014, the resident indicated he/she thought the catheter was changed last week.

Upon review of the Resident #004's health record, it was documented that Resident #004 was admitted to the home in July 2009 with an indwelling catheter for urinary retention. Quarterly, the physician has reordered the monthly catheter change. Upon review of the resident's most recent plan of care it was documented to change the catheter as per the physician's order, once per month using a #16 Fr catheter. The following note was documented in the Medication Administration Record (MAR): Change Catheter Every Month. The size of catheter and date of catheter change were not indicated, and no staff signature was found to indicate the date the catheter was changed in the month of December 2014.

In a review of the progress notes on December 18, 2014, no notes was found to indicate the date the indwelling catheter was changed for the month of December 2014.

During an interview with RPN #S114 on December 17, 2014 he indicated that the reminder to registered staff to change the catheter is documented by the Clinical Manager in the home's Agenda Book that is kept at the Nursing Station. RPN #S114 indicated that the night nurse is responsible to check the Agenda and copy any treatment such as catheter change, to the 24-hour report to remind day staff of treatment required for the coming day. In reviewing the Agenda with Inspector #545, RPN #S114 indicated that Resident #004's catheter was due for a change on a specific day in December 2014. He indicated that he was not working on specified day in December 2014, therefore was unable to validate if catheter was changed or not on that day and was unable to provide documentation to show that the catheter was indeed changed.

During an interview with the Clinical Manager Staff #S102 on December 18, 2014, she indicated that she had written "Change Resident #004's foley catheter" in the Agenda on the page for the identified day in December 2014. She indicated that the registered staff responsible for Resident #004 on that specific day was expected to change the catheter as per the physician order, then document in the progress notes that the catheter was changed, with details regarding size of catheter used, amount of fluid used to inflate balloon, status of return, how the Resident tolerated the procedure and how the catheter drained.

During an interview with the Director of Care (DOC) on December 19, 2014 she indicated that she reminds staff regularly that care provision, such as indwelling catheter change, requires documentation in the progress notes as well as outcomes of the care set out in the plan of care and the effectiveness of the plan of care. [s. 6. (9)]

2) Resident #015 is dependent on staff for feeding and is on a specialized diet. Staff assists the resident with both the specialized diet and fluids. During meal time on December 12, 2014, Inspector #599 observed staff feed Resident #015's specialized meals and fluids at breakfast and snack at 10.00.

In an interview on December 12, 2014, the dietitian stated that Resident #015 was on a specialized diet and that the Resident was to be fed by staff as the Resident was unable to feed self. Both registered staff and PSW confirmed that Resident #015 was unable to feed self and needed to be fed by staff as indicated in the plan of care.

Inspector #599 reviewed the daily food and fluid intake record for Resident #015 for the month of November 2014 and it was documented that staff offered and fed Resident #015 a specialized snack or fluid for the bed time nourishment.

Resident's #015's daily food and fluid intake record for the month of December 2014 was reviewed by Inspector #599. On the intake record for a specific day in December 2014 there was no record of food and fluid intake indicating that both afternoon and evening nourishment were offered or given to Resident #015, as well it was noted that a zero was recorded for fluid intake. The next day, there was no record of food or fluid indicating that Resident #015 was provided with evening nourishment. On the following next two days, there was no record of food or fluid intake indicating that Resident #015 received both the afternoon and bed time nourishment.

In an interview on December 12, 2014, the DOC stated that if there was no record or if a zero was entered on the resident daily food and fluid intake record, it meant that Resident #015 did not receive any food and/or fluid and the resident was not fed. [s. 6. (9)]

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 documentation of the provision of care set out in the plan of care, the outcome and effectiveness for all Residents with indwelling urinary catheters be done monthly and as required, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 53 (4) in that the home did not ensure that (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Resident #007 was admitted to the home in January, 2012 with diagnoses of depression and anxiety, including several other medical conditions. A note in the health record by the Psychogeriatric Outreach nurse and physician on specified day in May 2014 indicated

that Resident #007 was stable.

During an interview with Resident #007 on December 10, 2014, the resident indicated that he/she worried he/she would not be receiving good care because his/her roommate, Resident #025 said bad things about him/her to staff and other residents. On December 17, 2014 Resident #007 indicated to the inspector that he/she used to get along with the roommate but in the recent months the relationship deteriorated. Resident #007 added that the staff was aware of the situation but nothing had been done to resolve the issue. Resident #007 indicated several times that his/her dentures were loose and causing discomfort especially when eating. During conversation with Inspector #545, both dentures were observed moving in the resident's mouth.

On December 17, 2014 during interviews with PSW #S110, RPN #S114 and Clinical Nurse #S102—they all indicated that they were aware that Resident #007 was not getting along with his/her roommate Resident #025. No one was able to indicate exactly when the conflict had initiated.

PSW #S110 indicated that there were no strategies in the plan of care to direct staff on how to approach Resident #007 when he/she screamed or got upset with Resident #025, but he found that when he joked with the resident, that seem to be effective as he found that the resident had a good sense of humour. PSW #S110 indicated that he thought that the two Residents should not be sharing the same room. PSW #S110 indicated he had not noticed that Resident's dentures were loose.

RPN #S114 indicated he didn't know what triggered Resident #007's outburst of anger and conflicts with Resident #025 as he found the roommate to be a quiet and soft spoken person that got along with other Residents. The RPN indicated that BSO had been involved in the past as well as the Psychogeriatric nurse and the physician for management of mood disorder and for complaints of abdominal pain and pain in his/her heels. When asked if Resident #007 had complained of loose fitting dentures, he indicated he was aware of the issue and that the Clinical Nurse was looking into it.

During an interview with the Clinical Nurse #S102 on December 16, 2014 she indicated that Resident #007 had lost some weight since his/her admission to the home and that his/her dentures no longer fit properly. She indicated that a referral for new dentures had been done in the past but due to lack of funding, Resident #007 had decided to wait.

Upon review of Resident #007's most recent plan of care (October 2014), it was

indicated that the psycho-geriatric team saw Resident #007 at least once per month. The plan also indicated for staff to follow their suggestions, allow the Resident to gain some control over his/her care, suggest that he/she calls his/her family more often, to encourage the resident to express his/her feelings without any outbursts and monitor behaviour episodes and attempt to determine underlying causes, considering location, time of day, situation.

During an interview with the psychogeriatric nurse , on December 18, 2014, she indicated that she had not been informed of the conflicts between Resident #007 and his/her roommate. The nurse indicated that when the resident had conflicts in the past, the identified triggers were physical issues and once resolved Resident #007's behaviour would resolve. The psychogeriatric nurse indicated that it was the responsibility of the staff at the home to inform her when the team's services was required, and added that the last time she had visited Resident #007 in August 2014, the resident had been stable.

On December 18, 2014, the DOC indicated that it was the expectation that staff document Resident #007's behaviour and alert the psychogeriatric team as the team is available to provide assessment and support.

The Clinical Nurse #S102 indicated on December 18, 2014 that she had just reviewed the issues with the psychogeriatric nurse, and that an assessment and identification of behavioural triggers to the resident's responsive behaviours would be documented and the plan of care would be updated in January 2015 when the resident's RAI-MDS 2.0 assessment would be completed and would at that time include strategies to minimize Resident #007's responsive behaviours. [s. 53. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the behavioural triggers for the Resident #007 are identified, where possible; that strategies are developed and implemented to respond to Resident #007's behaviours, where possible; and that actions are taken to respond to the needs of Resident #007, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 60 (2) in that the licensee did not respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

The home's Family Council was established in June 2014. The meeting minutes including a letter sent to the Regional Director of Extendicare by the Family Council were reviewed for a period of six months between June 2, 2014 and November 24, 2014. In a letter sent to the Regional Director on November 24, 2014, the following concerns were documented by the Family Council:
- Family members being told by staff that continence care products were "out of stock"
- Not understanding the statement: "other services" as per the letter sent to Residents and families concerning the Ontario Property Tax Credit
- Lack of information provided regarding the allocation of funding

- Home's roof damage, and what repairs were done
- Lack of display of the newly hired Administrator's qualifications

During an interview with the President of the Family Council on December 11, 2014, she indicated that a meeting with the Regional Director (Extendicare) was scheduled for November 17, 2014 to discuss some of the concerns but due to a snow storm, the meeting was cancelled. The President indicated that on November 24, 2014, she presented a letter listing the concerns to the Regional Director (Extendicare) via the home's Office Manager, requesting a response in writing to each of the listed concerns. The President indicated that, on December 9 and 10, 2014 she requested the home to follow-up with the Regional Director (Extendicare) as she had not received a response to the letter that was sent on November 24, 2014.

During an interview with the Office Manager on December 15, 2014 she provided the Inspector with copies of two emails that was sent to the Regional Director (Extendicare) on behalf of the President of the Family Council; one dated December 9 sent by her, the other dated December 10, 2014, sent by Programs Manager #S122. In both emails it was documented that the Family Council President was requesting a response to the letter sent to her on November 24, 2014.

During an interview with the Program Manager, Staff #S122 on December 15, 2014 she indicated she had been assigned Assistant to the Family Council. The Programs Manager indicated she was aware that the Family Council had many concerns that were not being answered. She indicated that she sent an email, on behalf of the Family Council, to the Regional Director (Extendicare) on December 10, 2014 requesting a response. She indicated that a response had not yet been received, but that the Regional Director would be coming to the home the week of December 15, 2014 to address the issues in person.

During an interview with the Administrator on December 15, 2014, he indicated that neither he nor the Regional Director (Extendicare) responded in writing within 10 days of receiving Family Council concerns presented to the Regional Director in a letter dated November 24, 2014. [s. 60. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the home's infection control program.

1) On December 8, 9 and 10, 2014, odours of urine were noted to be present in the following resident rooms: #116, #118, #141 and #143. On December 11, 2014, Inspector #117 further examined the resident rooms and their bathrooms. It was noted that in the bathrooms of rooms #116, #118 and #141-143 (shared bathroom) there were urinary drainage bags that were hung from the towel bars. The bags were not identified as whom they belonged to, there was some clear to pale yellowish tint liquid in the bags and the connector tubings were not capped. In bathroom #141-143, the end of the connector tubing was observed to be lying on the bathroom floor. The residents who use these bathrooms, Residents #004, #007 and #011 all have indwelling urinary catheters. A review of their health care records shows that the above residents are identified as being at risk of urinary tract infections.

On December 11, 2014, Inspector #117 spoke with unit RPN #S107 and PSW #132 regarding the care and prevention of contamination of urine drainage collection bags. Both staff members stated that the drainage bags were cleaned with hot water and no other cleaning or disinfection products. As per PSW #S132 the urinary drainage bags were changed when the bags became discoloured, markings on the bag were faded, the bags leaked or the closing clamps were broken. The RPN #S107 stated that the PSW staff came on individual basis to request new urine collection bags. When asked about tubing caps to protect and prevent contamination of connector tubing when the bags were not in use, PSW #S132 stated that if caps were lost or disposed of, there were no replacement caps in the home.

On December 16, 2014, Inspector #117 examined the bathrooms of the 7 residents in the home who had indwelling urinary catheters. All of the nighttime urinary drainage bags not in use were noted to be hanging on the bathroom towel bars. Some liquid, varying from clear to yellowing liquid, was noted to be in all bags and the connector tubings were noted not to be capped. The following was also noted: Resident #011's and Resident #023 connector tubing was not capped and the tubing was approximately 1 inch above the floor. PSW staff #S112, #S117 and #S119 stated to Inspector #117 that they did not have any caps on the foley catheter tubing for drainage bags that are not in use. The connector tubing was left open to air but that the tubing should not be close to the floor. They also confirmed that they only use water to clean the urinary drainage bags and that they were not aware of any other cleaning process to clean the urinary bags and the connector tubing ends prior to connecting to the urinary foley catheter.

The Inspector #117 spoke with the DOC regarding the cleaning and prevention of contamination processes for the urinary draining collection bags. The DOC stated that the home did have a policy # CLIN-07-01-04H and # CLIN-07-01-04I related to the care and changing of urinary drainage bags. She was unsure if staff had received any training or were aware of the policy as she had just returned from an extended leave and this was a newer policy. The home's Clinical Nurse, who oversaw the infection control program during the DOC's extended leave, confirmed that there was no product (vinegar as per the policy) to clean the urinary drainage bags and no extra tubing caps in the home to prevent connector tubing contamination. She was also unaware that staff did not cleanse connector tubings with alcohol, as per the policies, prior to reconnecting the drainage bags to resident urinary catheters.

2) Resident #004 has an indwelling catheter for urinary retention.
On December 9 and December 16, 2014, Inspector #545 noted an odor coming from Resident #004's shared bathroom. In the bathroom, a large night bag was observed hanging on a metal bar below the bathroom cabinets. A small amount of clear fluid was observed at the bottom of the bag, along with brown stains on the seams of the bag. The catheter tube had no cap covering the end, and it was left open to the air. There was no information on the bag to indicate who it belonged to and when it was changed.

During an interview with PSW #S127 on December 18, 2014 she indicated that she was responsible to changing Resident #004's leg bag to his/her night bag when putting Resident #004 to bed in the evening. When asked to describe the procedure, PSW #S127 indicated that she emptied the leg bag using the urinal available in the bathroom, dumped the urine in the toilet, and then rinsed the leg bag with a small amount of water and some soap available from the dispenser in the shared bathroom. The PSW indicated that a new leg bag and night bag were provided once per month when the catheter was changed. She indicated that she never used a cap to cover the end of the catheter tube, that none was available. PSW #S127 indicated that she had been informed just today that a new procedure was in place but that she had not yet received training.

3) Resident #007 has an indwelling catheter for a chronic urinary retention with a history of chronic urinary infections.

On December 10 and December 16, 2014, Inspector #545 observed a lingering of odor of urine when entering Resident #007's shared bedroom. In the shared bathroom, a large night bag was observed hanging on a metal bar above the toilet. The catheter bag contained a small amount of yellow liquid in the bottom; the catheter tube was left open to the air, resting on top of the toilet tank, with no cap covering the end. There was no information on the bag to indicate who it belonged to and when it was changed.

During an interview with PSW #S110 on December 17, 2014, he indicated that in the morning when he got Resident #007 up for breakfast, he emptied the night bag. He indicated that he used water to rinse the night bag and that no disinfectant product was provided to clean the bag or the catheter tube. PSW #S110 indicated that caps were not available in the home and that he was never told to use one to cover the end of the catheter tube. When asked when he last received training on how to clean catheter bags, he indicated that catheter care training was never provided to direct care staff. [s. 229. (4)]

2. The licensee has failed to ensure that there 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.

1) On December 8, 9 and 10, 2014, Inspectors #545, #599, #126 and #117 observed that there were no hand hygiene agents in resident rooms. Hand sanitizer dispensers were observed to be located in unit hallway walls. There are 4 hand sanitizer dispensers per unit hallways. An examination of all resident rooms found that there was a plastic wall holder for a hand sanitizer product, in each resident room. However all but one wall holder were empty. No hand hygiene products were noted to be within access of resident point of care.

On December 11, 2014, PSW #S110 and Environmental Supervisor stated to Inspector #117 that the home used to have hand sanitizers in each resident rooms. The plastic wall holders for the sanitizers are still present in resident rooms. However the hand hygiene products were removed several months ago because of a resident who was to known ingest the hand sanitizer products. Both staff members stated that the resident in question is no longer in the home. To their knowledge, there has been no direction received to replace hand sanitizer products in resident rooms.

On December 15, 2014, Inspector #117 met and spoke with the home's DOC, Administrator and Nursing Consultant regarding the home's hand hygiene program and point of care access to hand hygiene agents. The DOC stated that the home had not done any staff education this past year on their hand hygiene program. Inspector #117 showed to the DOC, Administrator and Nursing Consultant the empty wall holders in resident rooms. The DOC, Administrator and Nursing Consultant were not aware that there were no hand sanitizer products available within access of resident point of care. The DOC, Nursing Consultant and Environmental Supervisor ensured that hand hygiene products were immediately put in the room of each resident to ensure point of care access to hand hygiene products.

2) While observing medication administration Inspector #599 observed registered staff member #S107 performing blood glucose test strip for Residents #017 and #018 and proceeded to administer eye drops to Resident #016. Staff member #S107 failed to perform any hand hygiene before or after the administration of the eye drops to Resident

#016. Immediately following the administration of the eye drops, Staff #S107 started preparing the medications for Resident #018 without performing hand hygiene.

During the medication administration for Residents #016, #017 and #018 staff member #S107 failed to participate in the implementation of the infection control program as it relates to hand hygiene. [s. 229. (9)]

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 1) there is a hand-hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; 2) to ensure that all staff that provide resident care have access to point-of-care hand hygiene agents and finally 3) to ensure that all staff participate in the implementation of the home's infection control program especially as it relates to indwelling catheters, to be implemented voluntarily.

WN #6: 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 has failed to comply with O.Reg 79/10 s. 33 (1) in that the home did not ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

1) During an interview with Resident #007 on December 10, 2014 the resident indicated

that staff gave him/her a bed bath twice weekly; added that the resident would prefer to be bathed in the tub bath. Resident #007 indicated he/she thought that staff preferred to give him/her a bed bath because he/she has a catheter and requires to be transferred with a mechanical lift. On December 17, 2014 Resident #007 indicated to the inspector that staff always gave his/her a bed bath just before supper on Monday and Friday.

Upon review of Resident #007's most recent plan of care, it was documented that the Resident required total assistance of two staff for transferring onto the shower chair or into the bath tub. It was also documented that Resident #007 preferred a shower although upon occasion received a tub bath. Resident #007's name was documented on the Evening Tub Bath Sheet (dated: Aug. 29, 2014) posted in the South Spa Room with a "D" for "douche" (shower) for Monday and Friday. The Daily Bath Record indicated that Resident #007 received 8 out of 12 bed baths and 4 out of 12 showers over a period of 6 weeks from November to December, 2014.

During an interview with PSW #S130 on December 16, 2014 , the staff member indicated that she offered a bed bath to Resident #007 on two specific days in December 2014. She added that Resident #007 often complained of pain and for this reason he/she accepted a bed bath. The PSW indicated that Resident #007 could no longer sit on a shower chair as his/her legs were too weak and a tub bath would be best for the resident.

The Clinical Nurse #S102 indicated that Resident #007 should be bathed by the method of his/ her choice twice weekly; added she was not aware that the resident was receiving bed bath twice weekly; added that there was no restriction for this Resident to be receiving tub bath even if the resident had an indwelling catheter in place. [s. 33. (1)]

2) During an interview with Resident #012 on December 9, 2014, the resident indicated he/she preferred a tub bath; however the staff offered and provided him/her with a shower twice weekly.

Upon review of Resident #012's most recent plan of care, it was documented that the Resident required extensive assistance from staff for bathing related to his/her cognitive impairments, obesity and arthritis. It was also documented that the Resident preferred a tub bath, twice weekly. The Bath Instruction sheet posted in the south tub room (dated: August 28, 2014) and in the Nursing Station (dated November 7, 2014), did not indicate a preference for a tub bath or shower for Resident #012. The Daily Bath Record indicated

that over the past month Resident #012 received 6 showers out of 8 times, 1 tub bath out of 8 times and for a specific week in November —the second bath was not documented.

During an interview with PSW #S110 on December 12, 2014, the staff member indicated that Resident #012's method of choice for bathing was a shower. Shortly after, Resident #012, in presence of PSW and Inspector #545 indicated that he/she preferred a tub bath and staff only offered him/her a shower. PSW #S110 indicated he was not aware Resident #012 preferred a tub bath.

On December 16, 2014, Clinical Nurse #S102 indicated that Resident #012 could receive a tub bath if this was the resident's preference, as he/she had no medical condition to contraindicate it. The Clinical Nurse indicated that the plan of care would be updated to include interventions to direct staff in covering Resident #012's pressure ulcer with a plastic bag to prevent the dressing from getting wet during the bath. [s. 33. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 37 (1) (a) in that the home did not ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

Resident #004 has moderate cognitive impairment and requires extensive assistance of one staff for personal hygiene, including brushing of teeth. It was documented in the PSW Daily Flow Sheet that the Resident brushed his/her teeth daily.

Resident #004 shares a bathroom with Resident #013.

During an interview with Resident #004 on December 9, 18 and 19, 2014, the resident indicated he/she did not brush his/her teeth or received assistance with dental care. Inspector #545 observed on those days that Resident #004 had several missing teeth and those remaining were grayish-brown in color. On December 18 and 19, 2014 two unlabelled toothbrushes (one maroon, one blue) with very dried bristles along with a tube of toothpaste were observed in a pink basket, with Resident #004's name on it, in the shared bathroom.

During an interview with PSW #S126 on December 19, 2014 she indicated that she had provided dental care assistance to Resident #004 that morning. When asked which toothbrush was used, PSW #S126 entered the shared bathroom and picked-up an unlabelled blue toothbrush with wet bristles from a ceramic cup placed in a gray basket, clearly labelled with Resident #013's name. When asked why she used Resident #013's toothbrush to brush Resident #004's teeth; she responded that the toothbrush belonged to Resident #004, and that she had been using this specific toothbrush daily for the past 8 months to assist Resident #004 with dental care.

During an interview with Resident #013 on December 19, 2014, he/she indicated to the Clinical Nurse and the Inspector that both toothbrushes (yellow and blue) in the ceramic cup were his/hers. The Clinical Nurse indicated she would immediately replace Resident #004 and Resident #013's toothbrushes and would label each toothbrush with residents' names to ensure staff did not use other Residents' toothbrushes by mistake. [s. 37. (1) (a)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the

licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 78 (2) (n) in that the licensee did not ensure that the package of information shall include, at a minimum, a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents.

On December 8, 2014, during the Entrance Conference, the Inspector provided the Administrator with the "Admission Process LTCH Licensee Confirmation Checklist". It was returned the same day, indicating that the Package of Information available to family or other persons of importance to the resident, did not include the disclosure of any non-arm's length relationship between the licensee and other providers who offer care, services, programs or goods to residents.

During an interview with the Administrator on December 12, 2014, he indicated that the home did not, at the present time have any non-arm's length relationship between the licensee and other providers who offer care, services, programs or goods to residents. The Administrator added that he would immediately add a paragraph, in the Admission Package, regarding "any non-arm's length relationship", as per legislation. [s. 78. (2) (n)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85(4)(a) in that the licensee did not ensure to document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

During an interview with the President of the Residents' Council on December 11, 2014, she indicated that the Satisfaction Survey results were attached to the Agenda of the November 28, 2014 meeting; added that Activity Assistant #S132 provided no explanation of the results to the members, in order seek the advice of the Council.

During an interview with the Programs Manager, #S122 on December 15, 2014 she indicated, that Activity Assistant #S132 who assisted at the November 28, 2014 Residents' Council meeting was expected to present the satisfaction survey results and seek advice of the Council. She showed the Inspector a copy of the minutes that indicated that "a copy of the results of the satisfaction survey was presented to each resident, and they were reviewed together with the Staff #S132 and that Residents expressed that they were happy to receive a copy and were happy with the results". The Programs Manager was unable to confirm if the results of the satisfaction survey was indeed reviewed with the members in order to seek their advice, as she was not present at the meeting.

On Dec 16, 2014, during an interview with Activity Assistant #S131, she indicated she had been assigned as Assistant to the Residents' Council. She stated that she distributed on November 28, 2014, a copy of the Satisfaction Survey results to the members who were present at the Residents' Council meeting. The Activity Assistant indicated that she informed the residents that the results of the survey were good. When asked by the inspector if she had seek the advice of the Residents' Council about the survey, she stated that she did not, and that she was not aware this was her role. [s. 85. (4) (a)]

2. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85(4)(a) in that the licensee did not ensure to document and make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

During an interview with the President of the Family Council on December 11, 2014, she indicated that Programs Manager Staff #S122 provided her with a copy of the results of the Satisfaction Survey in early Fall 2014, with a directive to share with the members of the Family Council. The President indicated that no discussion of the survey took place, and no feedback or advice about the survey was requested from the Family Council.

During an interview with the Programs Manager Staff #S122 on December 15, 2014, she indicated that the results of the Satisfaction Survey were provided to the President of the Family Council. Staff #S122 confirmed that there had been no discussion when the results were provided and no feedback or advice requested of the Family Council about the survey. [s. 85. (4) (a)]

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 87 (2) (d) in that the home did not ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

On December 8, 9 and 10, 2014 Inspectors #126 and #545 noted that there were lingering offensive odours in resident rooms #116, #118 and #143. A persistent strong smell of urine was present in the identified resident rooms as well as the bathrooms.

On December 11, 2014, Inspector #117 spoke with housekeeping staff member #S115 regarding the lingering offensive odours. The staff member stated that the odours have been present for several weeks. A product was being used by the home to help manage the odours of urine however this did not help with the smell of biological waste in room #128. She stated, that several weeks ago, housekeeping staff members were informed that the product was no longer available. The staff member stated that even though she cleaned all the walls, floors and counters in the identified rooms and bathrooms, the odours were persistent. PSW staff members' #S110 and #S132 confirmed that the identified rooms did have persistent odours of urine and biological waste even after the housekeeping staff had cleaned the identified rooms.

On December 11, 2014, Inspector #117 spoke with the home's Environmental Supervisor. He confirmed that due to budgetary issues, the home stopped purchasing a product that was a urine enzyme cleaner. This product was being used to help control lingering offensive odours in rooms #116, #118, #141 and #143. However, it did little to help with odours in room #128. The Environmental Supervisor stated that other, less costly products were trialled with little effect. He indicated that no investigation has been done into identifying and addressing the possible source of the odours. The home is only addressing the odours with the aid of cleaning products. He also stated that he is in communication with the home's cleaning product supplier to find a product that would help control biological waste odours in room #128. He did state that there still was a few bottles left of the urine enzyme cleaner in the home and would discuss the resumption of the product's use with the home's administration.

On December 15, 2014, Inspector #117 toured the home again. Ongoing lingering offensive odours of urine and biological waste were still present but less strong in rooms #116, #128, #141 and #143. Inspector #117 spoke again with housekeeping staff members #S115 and #S116. Both reported that the Environmental Supervisor did

provide to them that morning a urine enzyme cleaning product which they did use in the identified resident rooms and bathrooms. However the odours were present even with the use of the cleaning product. The odours were noted to still be present in the identified rooms on December 16, 17, 18 and 19, 2014. [s. 87. (2) (d)]

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. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 90 (2)(c) in that the home did not ensure that the procedures were developed and implemented to ensure that the heating, ventilation and air conditioning systems were in a good state of repair.

On December 8, 9 and 10, 2014, Inspectors #599 and #545 noted that the south wing tub room was in poor repair. The flooring was buckled along the window wall, the wall beside the tub was pitted and buckling, a 2 inch gap was noted between the floor and wall, exposing the sub-floor material which was wet from bath water. It was also noted that there was a strong smell of humidity in the room.

On December 11, 2014, Inspector #117 examined the south wing tub room. It was noted that the ceiling ventilation fan was not working when turned on. Inspector #117 spoke with Housekeeping staff member #S115 regarding the south side tub room. The staff member stated that the ceiling fan in the tub room has not been functioning for several months. She stated that she was unsure if this was reported to the home's maintenance department. This information was also confirmed by PSWs #S110, #S119 and #S120 who stated that the fan had not been working well for several months and the tub room was always stuffy, and humid with poor air ventilation. They were not aware if the problems with the fan were reported to the home's maintenance department as there had

been ongoing issues with the ceiling fan. They stated that it was reported to the previous management team but were unsure if the problems were reported to the home's new management team.

On December 11, 2014, Inspector #117 spoke with the home's Environmental Supervisor. He stated that he did have a plan to clean and ensure the good function of the home's ventilation, including ceiling fans in resident rooms and tub/shower rooms. He was not aware that the ceiling fan in the south tub room was not functioning. The Environmental Supervisor reviewed the maintenance logs. No information was noted in the logs in regards to any non-functioning ceiling ventilation fan.

On December 15, 2014, the Environmental Supervisor stated to Inspector #117 that he had assessed the ventilation issue in the south tub room on December 12, 2014. The ceiling ventilation fan was not functioning due to a burnt-out motor. The motor was replaced and the south tub room ceiling ventilation fan is now functioning correctly.

The home's south tub room ceiling ventilation fan was non-functioning at the time of the inspection and was repaired on December 12, 2014, only when this was brought directly to the attention of the home's Environmental Supervisor on December 11, 2014. [s. 90. (2) (c)]

Issued on this 30th day of January, 2015

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

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNE DUCHESNE (117), ANGELE ALBERT-RITCHIE (545), HUMPHREY JACQUES (599)
Inspection No. / No de l'inspection :	2014_198117_0032
Log No. / Registre no:	O-001278-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 16, 2014; Jan 29, 2015
Licensee / Titulaire de permis :	1663432 ONTARIO LTD. 2212 GLADWIN CRESCENT, UNIT A-9, SUITE 200, OTTAWA, ON, K1B-5N1
LTC Home / Foyer de SLD :	MANOIR MAROCHEL 949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PIERRE BERNIER

To 1663432 ONTARIO LTD., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is required to immediately remove the malfunctioning west unit tub chair from staff and resident use.
All nursing staff who are currently working in the home for day and evening shift, today on December 16, 2014, are to receive training on the use and operation of the new tub chair.
All other nursing staff are to receive training on the use and operation of the new tub chair by December 18, 2014.
The functionality and integrity of the new tub chair, on the west unit as well as the that of the old south tub chair are to be assessed/audited on a daily basis starting today, December 16, 2014. This is to continue when the new tub chair is received and installed in the south unit tub room.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 15 (2) (c) in that the licensee did not ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On December 16, 2014, at 09:45, PSW staffs #S112 and #S119 were getting Resident #019 for his/her tub bath in the west unit tub room. They seated the resident on the tub chair lift. The tub chair lift was activated, and the resident was elevated approximately 3 feet in the air when the tub chair lift suddenly stopped. PSW staff were unable to get the tub chair lift to function again. Inspector #117 was at the west unit nursing station, located in front of the tub

room when incident occurred. PSW #S119 came and got Inspector #117 to witness the problem with the west unit tub chair. Resident #019 was anxious but calm that the tub chair had suddenly stopped functioning. Both PSWs stated that they had changed the lift's battery and still the lift was not functioning. The PSWs stayed with Resident #019. They manually lifted the resident out of the tub chair lift and seated the resident in his/her wheelchair.

Inspector #117 went to the home's Administrator and DOC to advise them of the situation and the need to immediately remove the tub chair from use. The home's Environmental Supervisor, clinical nurse and RAI Coordinator came to the west unit tub room. They examined and removed the malfunctioning tub chair from use.

The new tub chair was brought to the unit. Training on its use is currently being organized by the home's DOC and Nursing Consultant.

It is noted that during Stage 1 of the RQI, several residents had reported to Inspectors #545 and #126 that they often could not have a tub bath due to a malfunctioning tub chair in the west unit tub room. During the Stage 1 tour of the home, several staff members had reported to Inspector #599 that the tub chairs, especially in the west unit tub room was occasionally malfunctioning.

On December 11, 2014, Inspector #117 examined the west unit tub chair. The chair's plastic covering was noted to be torn and missing around all of the seat and back edges, exposing the foam underlay. The metal lower frame, especially around the wheels was noted to be rusted. When the tub chair lift mechanism was tested, the chair did elevate, however it would not descend. The battery was turned off, then back on. The lift mechanism was tried, the chair did elevate, and only after 3 tries, did the descent mechanism activate. A tag on the chair indicated that the tub chair had last been inspected by Ontario Medical Supply (OMS) on July 25, 2014. No information related to the malfunctioning tub chair was noted in the home's maintenance logs. It was also noted that south unit tub room chair was examined and noted to be in the same condition as the west tub room chair. However, there was no noted issues with its lift mechanism.

On December 11, 2014, Inspector #117 spoke with the home's Environmental Supervisor regarding the west tub chair not functioning properly. The Environmental Supervisor stated that PSW staff had been reporting ongoing issues with the tub chair lift mechanism for several months. He stated that most

times, it was a battery problem where recharging was required. He indicated that the home's Administrator had ordered two new tub chairs for the home. He showed Inspector #117 that one of these tub chairs had just been delivered that same afternoon. When asked about plans for replacing the west tub room chair, the Environmental Supervisor stated that the Administrator did not want to replace any tub chair until both new chairs were received so that all staff could be trained at once and both chairs installed once the training was completed. He did not have any timelines as to when the second tub chair would be delivered.

On December 15, 2014, Inspector #117 spoke with several staff members PSWs #S112, #S118 and #S117, who all work on the west unit. The PSWs stated that they will test the tub chair prior to giving residents their scheduled tub bath to ensure that the tub chair was working prior to giving residents a bath. If it was not working, the residents were offered either a bed bath or a shower. The staff members stated that the tub chair had been frequently malfunctioning for the past several months and that this issue had been reported to the home's management. On December 15, 2014, Inspector #117 spoke with the home's Administrator regarding the west unit tub chair. He confirmed that new tub chairs had been ordered several weeks ago. One had been delivered to the home on December 11, 2014 and that he did not have a timeline for the delivery of the second tub chair. The Administrator stated that the new tub chairs would only be installed in the tub rooms once both tub chairs were delivered and all staff trained on their use.

On December 16, 2014, at 10:15 am, the home's Program Manager, who acted as liaison with various service providers, confirmed to Inspector #117 that the new tub chairs were ordered on November 24, 2014. One had been delivered on December 11, 2014. There was no timeline as to when the second tub chair was to be delivered. She confirmed that the west unit tub chair was serviced by Barton Medical, a medical equipment vendor, on the following dates:
-March 21 2014: to repair a malfunctioning hand set controller
-July 25, 2014: annual inspection
-October 15, 2014: to assess malfunctioning lift mechanism. No issues identified at that time as per Program Manager.
-All other issues with the malfunctioning lift mechanism were addressed internally. There was not written log documenting the lifts malfunctioning issues.

(117)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 16th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNE DUCHESNE

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