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

Division de la responsabilisation et de la performance du système de santé
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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
Feb 25, 2016	2016_457630_0003	000863-16	Resident Quality Inspection

Licensee/Titulaire de permis

MEADOW PARK (LONDON) INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

MEADOW PARK (LONDON) INC.
1210 SOUTHDALE ROAD EAST LONDON ON N6E 1B4

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

AMIE GIBBS-WARD (630), ALI NASSER (523), CAROLEE MILLINER (144), HELENE DESABRAIS (615)

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): February 9, 10, 11, 12, 16, 17, 18 and 19.

The following were completed concurrently within the RQI: Complaint log #026358-15 related to multiple resident care concerns; Complaint log #030143-15 related to staffing levels; Complaint log #002706-16 related to medication administration; Complaint log #001552-16 related to respite care; Critical Incident log #024680-15 related to medication storage; Critical Incident log #030562-15 related to falls; Critical Incident log #034179-15 related to multiple resident care issues; and Critical Incident log #034390-15 related to alleged resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator of Meadow Park London, the Administrator of The Villa, the Director of Care, the Co-Director of Care, the Staff Educator/RAI-MDS Co-ordinator, the Food Services Supervisor, the Restorative Care Co-ordinator, the Registered Dietitian, two Dietary Aides, two Environmental Services Supervisors, 16 Personal Support Workers, a Behavioural Supports Ontario Personal Support Worker, four Registered Practical Nurses, two Registered Nurses, the Resident Council President, four family members and over 40 residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **8 WN(s)**
- **7 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

Findings/Faits saillants :

1. The Licensee has failed to ensure that the home is a safe and secure environment for its residents.

a) Observations identified two residents unsupervised in an unlocked dining room. Within this dining room there was no door or barrier separating the food service area and there was a functional hot beverage machine as well as a steam table, accessible to residents.

Interview and observations with Co-Director of Care #107 confirmed that the door for this dining room should be closed when unattended. Administrator #100 confirmed that it was the expectation of the home to have the doors closed and locked and residents would attend the dining room only when supervised. It was also confirmed that it was the expectation that residents would be safe in the home and not at risk from the steam table or hot beverage machine.

b) Observations of the food service area in dining room identified no doors or barriers to restrict entry to this area with a hot beverage machine and steam table accessible to residents. Interview with Dietary Aide #108 identified that the steam table was in the dining room all the time and was never moved. Dietary Aide #108 indicated that the hot beverage machine as well as a steam table both were functional and able to be turned on.

Observations revealed that a dining room had five residents unsupervised in the area and the steam table felt hot and water temperature measured 70 degrees Celsius. Inspector #523 brought this to the attention of Administrator #100 who confirmed the steam table felt hot and that resident with cognitive impairment in the dining room with no supervision were at risk for their safety.

Administrator #100 confirmed that it was the expectation of the home to have the doors closed and locked and resident would attend the dining room only when supervised. It was also confirmed it was the expectation that residents would be safe in the home and not at risk from the steam table or hot beverage machine. [s. 5.]

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 the dining rooms on the main floor of the home are safe environments for the residents, 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for a Personal Assistance Service Device (PASD) provided clear direction to the staff who provided direct care to the resident.

An identified resident was observed over four days using a PASD.

Interview with Restorative Care Co-ordinator #132 identified that this resident used this PASD for positioning and confirmed the plan of care did not include clear direction for this PASD. Interviews with Personal Support Worker (PSW) #109 and Registered

Practical Nurse (RPN) #118 identified they were not clear about the plan of care for this PASD.

Review of plan of care and kardex for this identified resident provided no guidance for the frequency to adjust this PASD.

Interview with Co-Director of Care (Co-DOC) #107 confirmed that the plan of care related to this PASD did not provide clear direction to staff. The Co-DOC #107 also indicated it was the expectation of the home that the plan of care related to PASDs would provide clear direction to staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure the plan of care was based on assessment of pain and the needs and preferences of the resident for pain relief.

An identified resident was observed with a pained facial expression calling for help and expressing pain. This resident indicated to inspector that he/she had rung the bell and a staff person had responded by turning it off and then left without providing care. This resident reported a preference to go to bed after meals for comfort.

Inspector reported to PSW #109 the pain expressed by this resident. PSW #109 indicated that this resident usually went to bed after meals for comfort and confirmed that the staff had not responded to the request to go to bed.

Interview with PSW #117 indicated that this identified resident often complained of pain but could not identify interventions to assist with pain relief for this resident apart from reporting it to the registered staff.

Interview with RPN #110 indicated this resident frequently complained of pain and was receiving pain medications but identified no other interventions to monitor for pain or for pain relief. RPN #110 reported pain assessments were done for residents with new pain but chronic pain was assessed quarterly through the Minimum Data Set (MDS) assessment.

Review of the clinical record for this resident identified that the most recent MDS assessment showed "daily pain" and "times when pain is horrible or excruciating" but did not include further assessment of the type and location or the effectiveness of interventions. The most recent pain assessment in PCC was dated March 2015. The medication administration record and progress notes showed this resident had received

"as needed" pain medication thirteen times during a twelve day period but there was inconsistent documentation of the location, intensity or type of pain.

The plan of care for this identified resident did not include a focus on pain and therefore did not have goals or interventions related to pain. The plan of care also did not include the resident's stated preference for lying down after meals to support comfort.

Interview with Co-DOC #107 confirmed this resident did not have a recent pain assessment completed and did not have a plan of care in place for pain. Co-DOC #107 indicated it was the expectation of the home that pain assessment would be completed for unrelieved chronic pain and a plan of care in place based on that assessment. [s. 6. (2)]

3. The licensee has failed to ensure that the care set out in the plan of care for vision was based on an assessment of the resident and the needs of that resident.

Review of the plan of care for an identified resident revealed the resident had impaired vision and included interventions to assist the resident.

Review of most recent Minimum Data Set (MDS) assessment for this resident dated December 2015, revealed that the resident had impaired vision and did not wear glasses.

Interview with Personal Support Workers (PSW) #115 and #114 and Registered Practical Nurse (RPN) #118 revealed that they were unaware that this resident had vision impairment.

Interview with RPN #118 confirmed that this resident had vision impairment and that the plan of care was not individualized to the resident's needs. [s. 6. (2)]

4. The licensee failed to ensure the plan of care for urinary incontinence and repositioning was provided to the resident as specified in the plan.

A family member of an identified resident reported that this resident was usually repositioned and changed earlier in the day but was concerned that this care had not yet been provided. This family member indicated he/she had been at the home for a few hours and that this resident had not been changed during the time of the visit and had a wet product. This family member reported that the staff working was aware of the

concern but they had said they were "short staff". This family member indicated he/she did not want to leave the resident until the product was changed due to past experiences when the resident's product was soaked when he/she came to visit in the evening due to not receiving care in the afternoon.

PSW #109 and RPN #110 who were responsible for providing care to this resident on that day shift indicated that there were residents who had not received assistance after lunch including this resident. They identified this was because there was not enough staff available at the time to assist.

Review of clinical record for this resident showed that Point of Care (POC) included the intervention to reposition every two hours. Plan of care for incontinence included "check for wetness before and after meals". The PSW documentation in POC for that that day showed no charted repositioning for over eight hours and no charted continence product check or change for over eight hours.

Interview with Co-Director of Care #107 identified it was the expectation that the documentation reflected the care and that if care for repositioning and continence care was not documented it was not possible to confirm that the care had been provided.

Interview with Administrator #101 on February 12, 2016, identified that home area had their usual staffing levels for PSW and registered nursing staff that day and were not "short staffed". It was confirmed that it was the expectation of the home that residents would receive assistance with continence care and repositioning as per the plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that each plan of care is based on an assessment of the resident and the needs and preferences of that resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee has failed to ensure that the policy and procedure related to updating the plan of care for residents was complied with.

A review of the home's policy titled "Resident Rights Care and Services-Plan of Care" effective September 16, 2013, with Administrator #100 revealed that "all interdisciplinary members involved in developing the plan of care will: update care plan based on subsequent assessments within 14 days of Assessment Reference Date (ARD)."

Clinical record review for an identified resident revealed that the resident's assessment was completed on a specified date.

Interview with Administrator #100 confirmed the plan of care for this resident was not updated within 14 days of the completion of the assessment as per the home's procedure. It was also confirmed that it was the expectation that the staff comply with the home's procedure. [s. 8. (1) (b)]

2. The Licensee has failed to ensure that the policy and procedure related to food temperature monitoring was complied with.

Interviews with four identified residents indicated they had concerns with the temperature of the foods served in the home.

Interview with Food Services Supervisor (FSS) #119 indicated residents had expressed concerns regarding the food temperatures through the Resident Food Committee. She identified they had recently implemented a new policy and temperature sheets for temperature monitoring due to concerns in the home with food temperatures.

Review of the home's "Point of Service Temperatures" policy last revised January 19, 2016, showed the purpose of the policy was to "ensure that residents receive food at appropriate temperatures". The policy further directed that the dietary staff would "record point of service temperatures in Celcius of all menu items approximately five minutes prior to the commencement of the meal" and "record food temperatures following meal service for any food remaining".

Review of the "point of service" temperature record sheets for an identified dining room with the Food Services Supervisor #119 confirmed that this record was incomplete for all meals during this four day period. Food Services Supervisor #119 confirmed that the policy regarding recording food temperatures had not been complied with and that it was the expectation of the home that temperature records would be completed before and after each meal based on the home's policy. [s. 8. (1) (b)]

3. The licensee has failed to ensure the policy for weight monitoring was complied with.

a) Clinical record review for an identified resident showed the resident had a significant weight change of more than two point five kilograms between two months but the resident was not reweighed.

Review of home's policy titled "Monthly Weights and Weight Variance Report" last revised on November 4, 2011, identified that "the PSW will reweigh residents with 2.5

kilogram change in weight from most recent weight".

Interview with Food Services Supervisor (FSS) # 119 confirmed that this resident was not reweighed as per the procedure and confirmed that it was the home's expectations that the staff would comply with its own policies and procedures. (523)

b)Clinical record review for an identified resident showed the resident had a significant weight change of more than two point five kilograms between two months but the resident was not reweighed.

Review of home's policy titled "Monthly Weights and Weight Variance Report" last revised on November 4, 2011, identified that "the PSW will reweigh residents with 2.5 kilogram change in weight from most recent weight".

Interview with Registered Dietitian (RD) #104 on February 16, 2016, confirmed this resident had not been reweighed after this significant weight change and this had made it difficult to assess the resident. RD #104 indicated this policy was not complied with on a regular basis and it was the expectation in the home to complete reweights for residents based on the policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy related to skin and wound care, weight monitoring, resident plan of care and food temperature monitoring are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily accessed and used by residents at all times.

Observations in an identified resident room revealed that the communication system in the resident bathroom did not engage when the call bell was pulled.

Administrator #100 confirmed the resident-staff response system in this room could not be used properly by residents in this room. Administrator #100 indicated it was the home's expectation that all resident-staff communication and response system, be easily accessed and used by residents at all times. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's pain was reassessed using a clinically appropriate assessment instrument after the pain was not relieved by the initial interventions.

An identified resident was observed to be in pain and reported he/she felt pain on a regular basis. Interview with RPN #110 confirmed that this resident expressed pain at that time and on a regular basis.

Review of the Point of Care (POC) documentation for this resident for that day showed PSW documented "expressing pain verbally or through behaviour " and "reported to charge nurse". Review of point click care progress notes and electronic Medication Record (eMAR) for that day identified no documentation by registered staff regarding this expressed pain .

The next day this resident was observed to be in pain and stated that he/she was in pain. This resident again reported having pain on a regular basis. Interview with Co-Director of Care #107 and RPN #110 confirmed this resident was reporting and showing signs of

pain.

Interview with RPN #110 indicated this resident frequently complained of pain and that it was difficult for staff to assess whether it was actual pain or behaviours. RPN #110 reported resident #036 received pain medications but identified no other registered staff interventions to monitor pain or for pain relief. RPN #110 reported pain assessments were done for residents with new pain but chronic pain was only assessed quarterly through the MDS assessment.

Review of the Point of Care (POC) pain monitoring by PSWs showed that between during an identified thirteen day period this resident had "expressed pain verbally or through behaviour" on eight out of the thirteen days.

Review of the clinical record for pain monitoring and assessments for this resident identified that the most recent MDS assessment showed "pain less than daily" and "moderate pain" but did not include further assessment of the type, frequency or effectiveness of interventions. The most recent pain assessment in PCC was dated February 2015. The medication administration record and progress notes showed this resident had received "as needed" pain medication thirteen times in an identified one month period but there was inconsistent documentation of the location, intensity or type of pain. Physician assessment note dated in February 2016, indicated resident was complaining of pain. There was no documented evidence that a clinically appropriate assessment instrument had been used.

Interview with Co-Director of Care #107 on February 16, 2016, confirmed that this resident had not had a recent pain assessment and that it was the expectation of the home that residents with chronic unrelieved pain would have a comprehensive pain assessment completed. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with pain that is not relieved by initial interventions is assessed using clinically appropriate assessment instrument, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food was served at a temperature that was both safe and palatable to the residents.

Review of Resident Food Committee minutes from January 19, 2016, identified that the temperature of the sandwiches were a concern to the residents and included "some sandwiches don't seem very cold". The Administrator #100 responded in writing to this concern on January 26, 2016, stating "thank you for your comments on the temperature of sandwiches, our Food Service Manager is aware and is following up on this and we are confident it has been addressed".

Observations at lunch meal service in an identified dining room on February 17, 2016, found that the regular and pureed texture salmon sandwich temperatures at the start of the meal service were recorded as 10 degrees Celsius. Interviews with Dietary Aide #139 and Food Services Supervisor #119 confirmed the temperatures of the sandwiches were not within the acceptable meal temperature of four degrees Celsius or less.

Review of temperature record for this dining room lunches from February 11, 2016, to February 18, 2016, identified four out of seven lunch meals (57 per cent) had cold entrée items with recorded temperatures out of range as follows:
- February 11, 2016, cheese sandwich eight degrees.
- February 16, 2016, cheese salad plate ten degrees.
- February 17, 2016, salmon salad sandwich ten degrees.
- February 18, 2016, sliced turkey salad plate eight degrees.

Interview with Food Services Supervisor #119 confirmed that residents had expressed concerns regarding the cold food temperature through the Resident Food Committee and it was the expectation of the home that cold foods would be served at temperature of four degrees Celsius or less to ensure it was safe and palatable for the residents. [s. 73. (1) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that cold food items are served at a temperature that is safe and palatable to the residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, that there were schedules in place for routine, preventative and remedial maintenance.

Observations during the RQI identified damaged walls, scraped door frames and/or damaged or missing room fixtures in 14 out of 40 (35 per cent) resident rooms. Observations of these rooms on February 19, 2016, with Environmental Services Supervisor #135 confirmed these maintenance concerns.

A review of the home's "Preventive Maintenance Logs and Audits" with Environmental Services Supervisors #135 and #140 revealed there was no documented evidence that routine and remedial maintenance schedules were kept for painting and repairs to residents rooms.

Interview with Environmental Supervisors #135 and #140 confirmed that a log and schedule had not been kept of the work and repairs to be done in residents rooms and that the expectation of the home was that a schedule of required work and repairs would be kept as part of the organized program of maintenance services. [s. 90. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the organized program of maintenance services, that there were schedules in place for routine, preventative and remedial maintenance, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Observations during the RQI revealed that the tub room door in an identified home area was unlocked and propped open, and the tub room was unattended. At that time of observation nine residents were in the near vicinity of the tub room. Interview with Co-DOC #107 confirmed that most of those residents were cognitively impaired and there was a safety risk. Co-DOC #107 confirmed it was the expectation of the home that the door should always be closed when unsupervised by staff. [s. 9. (1) 2.]

Issued on this 25th day of February, 2016

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

Original report signed by the inspector.