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

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Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 25, 2014	2014_362138_0009	O-000497-14	Resident Quality Inspection

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6

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

PETER D. CLARK CENTRE
9 MERIDIAN PLACE, OTTAWA, ON, K2G-6P8

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

PAULA MACDONALD (138), AMANDA NIXON (148), LYNE DUCHESNE (117), RUZICA SUBOTIC-HOWELL (548)

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): June 10-13 and 16-20, 2014

Complaint Inspection O-000338-14 was completed in conjunction with the RQI. It should be noted that concurrent Long Term Care Homes Inspector training occurred during the RQI. The following Long Term Care Homes (LTCH) Inspectors were present for the purpose of training: Peggy Skipper Master Trainer), Gillian Chamberlain (#593), Melanie Sarrazin (#592), and Humphrey Jacques (#599).

During the course of the inspection, the inspector(s) spoke with residents, family members, the Administrator, the Manager of Resident Care, Manager of Personal Care, the Food Services Supervisor, the Manager of Recreation, Leisure & Volunteer Services, the Manager of Hospitality Services, the RAI-MDS Coordinator, the Facilities Supervisor, the President of the Residents' Council, the President Family and Friends Council, the Registered Dietitian, a Restorative Rehab Assistant, a Physiotherapy Assistant, the Pharmacist, a Dentist, several food service workers (FSWs), several personal support workers (PSWs), several housekeeping aides, several registered nurses (RNs), several registered practical nurses (RPNs), and maintenance staff.

During the course of the inspection, the inspector(s) reviewed residents' health care records, reviewed home's policy and procedures, toured resident rooms, toured resident common and non common areas, reviewed Residents' Council and Friends and Family Council minutes, observed several medication passes, observed several lunch meal services and snack passes, observed the delivery of resident care and services, and observed staff - resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to comply with O.Reg 79/10 s. 17. (1) (a) in that the licensee of a long-term care home failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

It was determined that the home uses a resident-staff communication system commonly referred to as a call bell system in which a person in any resident room can send a signal for assistance by engaging a button on a cord attached to a call bell station or, in a resident washroom, can pull a call bell pull cord that engages the pull station to send a signal. The signal for the call bell system once engaged is a light that is activate outside the door of the resident's room, a page to a pager carried by staff members indicating the room and location, and an audible alarm along with location display on a panel at the nursing station.

During Stage 1 of the Resident Quality Inspection (RQI) conducted June 10, 11, and 12, 2014, it was noted by Long Term Care Homes (LTCH) Inspector #138 that the call bell pull cord in resident washrooms in the Bungalows rooms 103, 109, 112, 301, 302, 307, 403, 405, and 409 was made from a white string like material that were short, measuring not more than eight inches in length, and were not long enough to be able to be attached to the grab bar near the toilet or placed with a resident sitting on the toilet. It was also noted by the inspector that the call bell station and pull cord in these

identified washrooms were located on the same wall as the toilet and in such a way that it would necessitate a resident who was sitting on the toilet to reach behind and stretch in order to even potentially reach the call bell pull cord. In most cases, due to size, residents would not be able to reach the call bell pull cord, thus the call bell pull cord would not be accessible to residents.

LTCH Inspector #117 also observed during Stage 1 of the RQI on Maple and Elm houses that there were pull cords in resident washrooms that were not accessible to residents for a variety of reasons. Specifically, it was noted in Elm house in room 104 and 154 and that the call bell pull cords were a red plastic-like material that were short, could not be placed on the grab bar, and could not be reached by a resident sitting on the toilet. Further, it was noted by the same inspector on Maple house room 210 that the call bell pull cord, which was made of a red plastic-like material, was pinned to the wall with a metal bracket that prevented it from being given to a resident seated on the toilet. This pull cord was also out of reach of a resident who would be seated on the toilet. In room 253 on Maple house, it was noted by the inspector that the call bell pull cord was long enough to reach a resident seated on the toilet but that the pull cord had been pinned to the wall with a metal bracket. It was noted that the metal bracket provided enough resistance to prevent the red, plastic-like material pull cord from engaging the call bell when it was pulled.

LTCH Inspector #599 observed on Pine house during Stage 1 of the RQI that the resident washroom in room 215 had a call bell pull cord that was a red, plastic-like material, that was short and would not reach the resident while seated on the toilet, and that it was out of reach of a resident who would be seated on the toilet.

On June 13, 2014, LTCH Inspector #138 spoke with a registered nurse on the Bungalows, Staff #115, regarding the length of the call bell pull cords in the resident washrooms. Staff #115 stated that all the pull cords in the resident washrooms in the Bungalows (the Bungalows houses 48 resident beds) are short and that it was believed that they were shortened for potential resident safety reasons a long time ago.

On June 13, 2014, LTCH Inspector #138 spoke with maintenance staff, Staff #148, who was in the Bungalows conducting maintenance work. The inspector asked about the length of the call bell pull cords and Staff #128 stated that he believed that some of the pull cords had been broken over the years and then made shorter both as a maintenance/housekeeping issue as well as a resident safety issue. Staff #148

further stated that all pull cords were supposed to have been replaced with a new red, plastic-like product that was stronger and easier to clean. Staff #148 stated he has replaced his assignment of pull cords in the houses about three months ago and was unsure why the pull cords were not replaced in the Bungalows.

On June 13, 2014, LTCH Inspector #138 spoke with the Facilities Supervisor regarding the call bell pull cords in the Bungalows. The Facilities Supervisor stated that the pull cords in the home had previously been made of string that were easily broken and difficult to clean. He further stated that the home's lead for the infection prevention and control program had wanted the call bell pull cords replaced with a red plastic-like product that was stronger and easier to clean. The Facilities Supervisor stated that he opened a work order in September 2013 to have all the call bell pull cords in the home replaced and further stated that the work order was closed in May 2014. The inspector stated that the pull cords in the Bungalows have not been replaced and the Facilities Supervisor stated that he opened a new work order earlier that day after learning from the maintenance staff in the Bungalows that the pull cords had not been replaced as expected.

LTCH Inspector #138 and LTCH Inspector #599 toured the home on June 16, 2014 and verified that the call bell pull cord in the resident washrooms in the Bungalows were not accessible to residents due to their length. While in the Bungalows, LTCH Inspector #138 spoke with Resident #020 who stated that s/he is assisted by staff to the toilet and then left unattended. The resident further stated that s/he is not able to use the call bell to request assistance as s/he can not reach the call bell pull cord. The resident further stated s/he is required to wait until staff are ready to assist him/her off the toilet. The inspectors continued to the houses and verified that the call bell pull cords in resident washrooms in Elm house rooms 104 and 154, Pine house room 215, and Maple house 210 and 253 were the pull cords made of a red plastic-like material and were not accessible as observed in Stage 1.

On June 16, 2014, LTCH Inspector #138 spoke with the Program Manager of Resident Care regarding the call bells pull cords that were observed to be inaccessible to residents in Stage 1. The Program Manager of Resident Care stated that long call bell pull cords were considered a safety risk to residents and that the replacement of the pull cords was related to infection prevention. The Program Manager of Resident Care further stated that it was unknown if accessibility of the call bell pull cords was considered when the call bell pull cords were replaced.

On June 16, 2014 LTCH Inspector #138 spoke with the Manager of Personal Care, who was identified as the lead for the home's infection prevention and control program, regarding the replacement of the call bell pull cords. The Manager of Personal Care stated that the call bell pull cords were to be replaced in the home with a new product that was red and that was easier to clean. The Manager of Personal Care stated that he was under the impression that the pull cords were all replaced. The inspector discussed with the manager that the call bell pull cords in the Bungalows had not been replaced and also discussed inaccessibility of the call bell pull cords in the Bungalows as well as the inaccessibility of several call bell pull cords, mentioned above, that had been replaced with the new red, plastic-like material. The Manager of Personal Care stated to the inspector that he would look into the accessibility of the call bell pull cords. [s. 17. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 9 (1) 2., whereby 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.

The clean and soiled utility rooms for each house (Pine, Maple, Elm and Willow) are located in an alcove on each side (east and west) of the unit. Each house has a total of four utility rooms, two on each side. On June 12, 2014, at 8:45am, LTCH Inspector #148 observed the clean and soiled utility rooms on the west side of Pine house. The doors leading to the clean and soiled utility rooms were observed closed and each

door was equipped with a lock. The utility rooms are located in an alcove, and at the time of the observation were not supervised by staff. Both the clean and soiled utility doors were observation to be closed and unlocked. Housekeeping staff member, Staff #117, was working one hallway and when asked by the inspector, indicated that these rooms are used by the nursing staff members. Staff #117, was not sure if the doors should be locked but proceeded to lock the doors. LTCH Inspector #148 informed nursing staff on the unit of the unlocked utility doors.

On June 12, 2014, at 8:55am LTCH Inspector #148 observed the utility room doors on the west side of Pine house. The doors leading to the soiled and clean utility rooms were observed to be closed and each door was equipped with a lock. The doors are located in an alcove and at the time of the observation were not supervised by staff. Both the clean and soiled utility doors were observed to be closed and unlocked. The inspector spoke with a personal support worker, Staff #105, who indicated that residents do not use the two utility rooms, but occasionally family will access the rooms. Staff #105 indicated that the doors may have been unlocked by the evening or night staff, as he recalls the doors to be locked at the end of the day shift yesterday. Staff #105 informed the registered nurse, Staff #107, of the unlocked doors. Staff #105 then proceed to lock both utility doors.

The home's Administrator identified the Manager of Recreation, Leisure and Volunteer Services or the Facilities Supervisor to be an appropriate manager to tour the home related to door security and safety.

On June 12, 2014, LTCH Inspector #148 observed the utility rooms on Pine house, with the home's Manager of Recreation, Leisure and Volunteer Services, who indicated that the utility rooms are a non-residential area and should be closed and locked as they are not supervised by staff members. During the tour, both the inspector and Manager of Recreation, Leisure and Volunteer Services observed the four utility rooms on Maple house, on both the east and west side. The doors leading to the four utility rooms on Maple house were observed to be equipped with locks and were observed to be closed and unlocked with no staff supervision.

On June 13, 2014, at approximately 9:15am, LTCH Inspector #148 observed the utility room doors on Pine and Maple houses and noted that all eight utility room doors were closed and unlocked without staff supervision.

Within each house there is a full kitchen available for staff to use in the preparation

and delivery of meal and snack service. Each kitchen includes four doors, two of the doors, both equipped with locks, lead to the east and west dining rooms. The third door, equipped with a lock, leads from the kitchen to a short corridor that then leads to a forth wooden door that is not equipped with a lock, which opens to the main corridor located between the east and west sides. The main corridor is a residential area, accessed and used by residents. On June 12, 2014, the kitchen doors were observed with the Manager of Recreation, Leisure and Volunteer Services. It was confirmed that on each of the houses, the wooden door which leads to a short corridor that then leads to the kitchen, is not equipped with a lock. The Manager of Recreation, Leisure and Volunteer Services reported that this short corridor and kitchen area are non-residential areas. During the tour of each house the inspector and Manager of Recreation, Leisure and Volunteer Services observed that the wooden door was not equipped with a lock and that the non-residential area, the short corridor leading to the kitchen, was unsupervised by staff.

On June 11 and June 12, 2014, LTCH Inspector #148 observed that the Pine, Maple, Elm and Willow houses, consist of one staff room. The staff room doors were found to be equipped with a lock, however, on observations of each staff room door, the inspector found the door to be open, unlocked and unsupervised. On June 12, 2014, LTCH Inspector #148 observed each of the four staff rooms with the home's Manager of Recreation Leisure and Volunteer Services, who indicated that the staff room is a non-residential area and should be closed and locked.

On June 13, 2014, LTCH Inspector #148 spoke with the home's Facilities Supervisor related to doors leading to non-residential areas. The Facilities Supervisor indicated that the utility rooms, staff rooms, kitchen and corridor leading to kitchen are considered non-residential areas and should be secure to prevent resident entry. [s. 9. (1)]

2. The licensee failed to comply with O.Reg 79/10, s.9 (1) 1. (iii), whereby the licensee did not ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access must be equipped with an audible door alarm that allows calls to be canceled only at the point of activation and is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

Peter D. Clark consists of two buildings known as the Houses and the Bungalows. Within the building known as the Houses, there are 4 resident areas (Pine, Elm, Maple and Willow houses). On each house there are two sides (east and west side); on each side there are two doors, one down each hallway, that lead to stairways. Between the four houses, there are a total of 16 doors that are accessible to residents that lead to stairways. Each door leading to a stairway was observed to be kept closed and locked and is equipped with a door access control system that is kept on at all times.

On June 13, 2014, LTCH Inspector #148, in the company of the home's Facility Supervisor, observed the doors leading to stairways on the Elm and Willow houses. The eight doors leading to stairways were observed to have no audible door alarm. Each door was opened using the home's access key card which unlocks the door access control system. The door was then held open at which time a signal was received by the resident-staff communication system and the audio visual enunciator at the nearest nursing station. No audible door alarm occurred at the point of activation. It was further noted, in the presence of both the Charge Registered Nurse, Staff #133 and the Facilities Supervisor that the signal sent to the enunciator could be canceled at the enunciator by lifting and hanging up the receiver attached to the enunciator. Observations confirmed that the signal activated at the stairway doors could be canceled at the nursing station enunciator and that the stairway door did not have a manual reset switch at the door. It was noted that within four of the eight stairways observed, that there was a door leading to an unsecured outside area, this door is not locked.

The main entrance/exit of the building known as the Houses consists of two sets of sliding doors that lead to the outside of the home. When exiting the building a person would first exit through the inner sliding door by using an access key card, once past the inner door the outer sliding door will open by motion detection. Both doors are equipped with a door access control system that is on at all times, the inner sliding door is kept closed and locked and is accessible to residents. On June 13, 2014, the main entrance/exit was observed with the Facilities Supervisor at which time it was confirmed that neither the inner or outer door is equipped with an audible door alarm. It was further confirmed that no alarm, associated with the main entrance/exit, is connected to the resident-staff communication system or to an audio visual enunciator that is connected to the nearest nursing station.

The main entrance/exit of the building known as the Bungalows, consists of two sets

of double doors that lead to the outside of the home. When leaving the resident's main living area to exit the home, a person would first need to exit though a set of locked double doors which lead to a foyer. Within the foyer there is a seating area, office space, conference room, a door leading to non-residential space and the main entrance/exit of the home. A person may also access the foyer through the nursing station, which includes two separate unlocked doors that connect the resident's living area to the foyer. During this inspection, observations of the vestibule including the presence of the WatchMate system at the main entrance/exit and observations of residents using the main entrance to enter and exit the building assist to define the vestibule as resident accessible. On June 16, 2014, LTCH Inspector #148 observed the main entrance/exit doors of the Bungalows. The outer double doors are kept closed but are unlocked and not equipped with a door access control system. The inner double door is kept closed and locked and is equipped with a door access control system that is kept on at all times. During the observation it was confirmed that the inner door does not have an audible door alarm and no alarm, associated with this entrance/exit, is connected to the resident-staff communication system or to an audio visual enunciator that is connected to the nearest nursing station. This was confirmed with the registered nursing staff, Staff #113.

Within the Bungalows, located between the inner and outer double doors of the main entrance/exit, there is a door leading to a stairway. The door is kept closed and locked and is equipped with a door access control system that is kept on at all times. On June 16, 2014, LTCH Inspector #148 observed the door to not be equipped with an audible door alarm nor was an alarm, connected to the resident-staff communication system or to an audio visual enunciator that is connected to the nearest nursing station.

The above observations of June 13 and June 16, 2014 were reviewed and confirmed with both the home's Administrator, Manager of Resident Care, Facilities Supervisor and the Manager of Recreation Leisure and Volunteer Services . [s. 9. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s. 129 (1) (a) (ii) in that the licensee failed to ensure drugs are stored in an area or a medication cart that is secure and locked.

On June 13, 2014 it was observed at 09:20 hours by LTCH Inspector #599 an unattended medication cart with a medication and a filled medication cup containing an unidentified white liquid. The cart was observed in a resident common area.

On June 13, 2014 it was observed at 09:45 hours by LTCH Inspector #548 on an unattended medication cart with two prescribed medications left on top of the cart. The cart was observed in a resident common area.

On June 13, 2014, LTCH Inspector #548 interviewed Staff #130 who indicated that all medications are to be stored safely in the medication cart.

On June 13, 2014 it was observed by LTCH Inspector #548 and LTCH Inspector #592 prescription and non-prescribed drugs in several resident rooms or areas. It was observed in:

- Resident #067's bedside a tube of Clotrimaderm 10mg/g 1 % topical cream,
- Resident #802's bedside: Clotrimaderm 10mg/g 1 % topical cream, Diovol Plus Antacid oral suspension, Sandoz Anuzinc paste in a tube and, Refresh eye drops,
- A resident shared bathroom a full container of Fleet enema by the bathroom sink and,

- Resident's #738's bathroom a container of Maalox oral liquid.

In addition, on June 13, 2014, LTCH Inspector #548 interviewed Staff #107 who indicated that it was brought to her attention by LTCH Inspector #599 that drugs were left at Resident's #718 bedside. Staff #107 indicated all medications that are administered require a physician's order and she will inform the physician of the medications observed in the resident's room.

On June 13, 2014 during an interview with Staff #130 she indicated that she was not aware that the drugs were left at the resident's bedside nor was she aware that the Fleet enema was left in a shared bathroom. Staff #130 indicated that the home's procedure is for topical creams to be are returned to the registered practical nurse by the personal support workers after its use.

On June 19, 2014 during an interview with the Manager of Resident Care Manager she confirmed that all medications should be stored safely in that they are secure and locked. [s. 129. (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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 131 (1) in that the licensee of a long-term care home failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

On June 11, 2014 it was observed by LTCH Inspector #548 for Resident #718 that there are several drugs residing on top of the resident's bedside table.

Upon record review on June 13, 2014 it was noted that there were no physician orders for the drugs observed in Resident #718's room.

On June 11, 2014, during an interview with a registered nurse, Staff #107, she indicated that she is not aware of the number of medications observed in the resident's room. Staff #107 indicated that she will inform the physician and request orders for those medications deemed appropriate.

On June 18, 2014, during an interview with the Manager of Resident Care she confirmed that prescribed medications are only to be administered to residents at the home. [s. 131. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure no drug is used by or administered to a resident unless the drug has been prescribed by the physician, to be implemented voluntarily.

WN #5: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c. 8, s. 6 (1) (a) in that a resident's written plan of care does not set out the planned care for the resident.

Resident #755 has cognitive impairments and utilizes a wheelchair with lap tray for mobility and positioning. On June 13, 2014, a personal support worker, Staff #128, stated to LTCH Inspector #117 that the resident's lap tray is used to help position the resident and support the resident when the resident is up in the wheelchair. Staff #128 stated that the resident is regularly repositioned in the wheelchair. This information was also confirmed by the registered practical nurse, Staff #127.

Resident #755's plan of care was reviewed by LTCH Inspector #117. It was confirmed by LTCH Inspector #138 upon entrance to the home with the Administrator who stated the plan of care was consider to be a hard copy of residents' care plan located in a

binder in each house and in the Bungalows. The plan of care for Resident #755 did identify that the resident mobilizes and is positioned in a wheelchair, that the resident is to be monitored hourly and repositioned every two hours however, the plan of care did not outline the use of a lap tray. Further, no information was found in the resident's chart related to the use of the lap tray as a positioning aid. Chart documentation only indicates that the resident is being monitored and repositioned but there is no information related to the application and use of the lap tray. The registered practical nurse, Staff #127 stated to LTCH Inspector #117 that the lap tray should be identified in the plan of care as the plan of care is the communication tool for the personal support workers providing care to the residents.

Resident #755's written plan of care does not identify the use of a lap tray as a positioning aid for the resident. [s. 6. (1) (a)]

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

Resident #782 was observed throughout the inspection to have both a lap belt and tabletop applied when in a wheelchair. The lap belt and tabletop were observed to be applied outside of meal or snack service. The resident's Restraint/PASD monitoring form for June 2014 was reviewed and indicated that the lap belt was applied during the day and outside of meal and snack service.

The resident's plan of care, as available to direct care staff members, indicated the use of a front closure lap belt when the resident is up in the wheelchair. The plan of care available within the electronic health care record indicated the use of truck restraint. The physician order, as indicated on the Physician Order Review form signed by the physician in May 2014, reads as follows: "Broda Chair with lap belt or table top with meals". The lap belt portion of this order was struck out by pen.

A registered nurse, Staff #107, indicated that the resident requires either the lap belt or table top to be in place to assist the resident with positioning, as the risk of falls is minimal due to the resident's lack of mobility. After reviewing the current physician orders, Staff #107 indicated that the lap belt may have been struck out as the devices are used for positioning. LTCH Inspector #148 spoke with personal support workers, Staff #106 and Staff #129, both of whom provide direct care to Resident #782. Staff

#106 reported that the resident requires either the lap belt or the table top but may sometimes wear both. Staff #129 reported that the resident has both the lap belt and table top in place when in his/her wheelchair. Neither staff were aware of the reasons for the physical devices.

The plan of care for Resident #782 does not set out clear directions to staff who provided direct care as it relates to the implementation of the resident's physical devices, specifically lap belt and table top. [s. 6. (1) (c)]

3. The licensee has failed to comply with LTCH 2007, S.O. 2007,c. 8, s. 6 (4) (b), in that the licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A review of Resident #001's progress notes on the June 16, 2014 indicated that in May 2014 the resident complained of mouth pain and advised wanting to see a dentist. The resident was told by the RPN on duty that the dentist is currently not available however a referral will be sent to the dentist. The resident was given pain control measures. The resident's power of attorney (POA) provided consent to have the resident assessed by a dentist. A message was left for the dentist regarding the resident's mouth pain.

Resident #001's progress notes reviewed on the June 18, 2014 indicated that the resident was seen by the in-house dentist in May 2014. The dentist determined the cause of the mouth pain. The dentist recorded the notes in the hard copy progress notes located in the resident's binder and left recommended care interventions in the unit's communication book.

On June 18, 2014, LTCH Inspector #117 and LTCH Inspector #593 met with the dentist. The dentist stated that she had written the care interventions in the resident's chart and nursing communication book but had not communicated verbally to nursing staff the resident's dental care needs. No information related to Resident #001's mouth pain and recommended care interventions were noted to be in the resident's current plan of care and Medication Administration Record (MAR).

During an interview on June 18, 2014 with LTCH Inspector #117 and LTCH Inspector #593, Resident #001 advised that s/he has continued mouth pain. S/He advised that

s/he was going to ask the unit staff to see the dentist again.

During an interview on June 19, 2014 with LTCH Inspector #117 and LTCH Inspector #593, the resident outlined an oral care routine that was not consistent with the dentist's recommendations and further stated that s/he will ask the nurse for something to help with the pain if the pain is significant. Resident advised that s/he was never given any instruction from the dentist or other staff regarding oral care.

On the June 19, 2014, a personal support worker, Staff #154, advised to LTCH Inspector #117 and LTCH Inspector #593 that she was unaware of any concerns related to the resident experiencing mouth pain or aware of any directives from the dentist regarding the resident's oral care. Staff #154 discribed an oral routine that was inconsistent with the recommendations from the dentist .

On the June 19, 2014, a personal support worker, Staff #153, advised to LTCH Inspector #117 and LTCH Inspector #593 that he was unaware of any directives regarding the resident's oral care or aware of any issues with the resident experiencing mouth pain.

(Log O-000338-14) [s. 6. (4) (a)]

4. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) (b) in that the licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

This inspection was initiated as a triggered item related to skin and wound care for Resident #738 from the Stage 1 RQI.

In May 2014 it is documented in the MDS assessment for Resident #738 for section M.2 (a) that the pressure ulcer was assessed as having a pressure ulcer. The resident was seen by physiotherapy and a dietitian.

During a record review for Resident #738, a progress notes with an entry date in May 2014 notes a diminished change in skin integrity and further described the pressure ulcer.

On June 16, 2014 during an interview with a registered nursing staff, Staff #107, she

indicated that the Resident #738 had a pressure ulcer when initially assessed in May 2014.

The plan of care for Resident #738 in effect at the time of the resident's altered skin integrity noted above was accessed from the binder in the nursing station. The plan of care indicated that the resident has a history of past pressure ulcers. The plan of care did not outline that the resident was experiencing current altered skin integrity.

On June 16, 2014 during an interview Staff #107 confirmed that the binder in the nursing station contains the plans of care for residents that are accessible to all staff. Staff #107 further stated that the plan of care are not always updated in a timely manner. [s. 6. (10) (b)]

5. The licensee failed to comply with LTCHA 2007 (6) (10) (b) in that the resident was not reassessed and the plan of care of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #738 has decreased mobility with impaired limb range of motion. The resident has a custom mobility and bed equipment to facilitate movement and provision of care. On June 10, 2014, Resident #738 informed LTCH Inspector #593 that nursing staff assist with him/her with daily personal care by giving the resident bed baths. However Resident #738 stated that instead of having a bed bath, s/he would prefer having a shower. This was reconfirmed with the resident on June 16, 2014. The resident's current plan of care identifies that the resident is to have a shower twice a week. Daily care flow sheets indicate that the resident is receiving two bed baths per week.

On June 16, 2014, a personal support worker, Staff #129, stated to LTCH Inspector #117 and LTCH Inspector #593 that Resident #738 does not receive any showers, but has been receiving bed baths for the past year. The unit registered nurse, Staff #107 stated that Resident #738 has been receiving a bed bath due to physical impairments and that Resident #738 has not expressed any wish to have a change in bathing methods. Rehabilitation staff, Staff #155, and a physiotherapy aide, Staff #156, stated to LTCH Inspector #117 and LTCH Inspector #593 on June 16, 2014, that Resident #738 has had a marked decreased in mobility and limb range of motion in the past year and had a health effect that further decrease the resident's mobility . They stated that based on quarterly mobility and physiotherapy assessment the resident does not

have the physical ability and strength to sit in a shower chair to take a shower. However, Resident #738 was not specifically reassessed regarding his/her abilities to sit in a shower chair, so that the resident could have a shower.

Resident #738's plan of care related to bathing was not reviewed and reassessed when the resident's health status changed in the past year and when the resident experienced a recent significant change in health status. [s. 6. (10) (b)]

WN #6: 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 failed to comply with O.Reg 79/10, s. 37. (1) (b) 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, cleaned as required.

During Stage 1 of the RQI 2014, it was observed by LTCH Inspectors #117, #543, #593, #592 and #599 on Pine, Elm, Maple, and Willow houses, that there were soiled resident cups, mugs, and kidney basins in several resident bathrooms. The cups, mugs and kidney basins are heavily soiled with white gummy and grainy residues. They also contain the residents toothbrushes, toothpaste, dentures and other personal care products or aids. The soiled glasses had some water in them.

On June 16 and 17, 2014 , soiled cups, mugs and basins in several resident rooms were shown to personal support workers, Staff #129, Staff #143 and Staff #144. These staff members stated to LTCH Inspector #117 and LTCH Inspector #593 that soiled cups, mugs and kidney basins are to be cleaned on an as needed basis. There is no set process to ensure that these are cleaned.

Interviewed housekeeping staff, Staff #149 and Staff #150 stated to LTCH Inspector #117 and LTCH Inspector #593 that they will occasionally remove soiled glasses from resident bathrooms and bring them for cleaning in the unit kitchen serveries. However, it is nursing staff's responsibility to ensure that cups, mugs and basins are cleaned.

On June 18, 2014, Manager of Resident Care stated to LTCH Inspector #117 and LTCH Inspector #593 that the home has no set process to ensure the regular cleaning of cups, mugs and kidney basins in resident bathrooms. These are to be cleaned by nursing staff on an as needed basis.

As such the home does not ensure that residents personal items are regularly cleaned. [s. 37. (1)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 37 (1) (a) in that every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including 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.

During Stage 1 and Stage 2 of the RQI from June 10 to 16, 2014, it was observed and noted by LTCH Inspectors #117, #138, and #593 that in several resident bathrooms on Pine, Elm, and Maple houses as well as the shared spa room in the Bungalows - 3 that resident personal items were not labelled to identify the resident to which that item belongs.

LTCH Inspector #117 observed on June 10, 2014 in the shared bathroom for rooms M264 and M263 on the counter and in two unlabeled gray baskets containing multiple unlabelled items. These items include sunscreen, shampoos, and several bottles of hand cream. LTCH Inspector #117 also observed in E154 bathroom unlabelled toothbrushes, toothpaste, periwash bottle, comb and mouthwash. In addition, in shared bathroom of rooms M255 and M256, there was observed to be unlabelled personal care items including a hair brush, Vaseline, toothpaste and a toothbrush. On the bathroom counter for room M256 there were several unlabelled items including deodorant, toothpaste and 2 toothbrushes.

LTCH Inspector #138 observed on June 11, 2014 in Bungalows 3 spa room that there were 4 white hair bushes and 2 silver hair brushes that had been used and not labelled. LTCH Inspector #138 spoke with a personal support worker, Staff #102,

regarding the brushes and Staff #102 stated that the brushes do not belong in the spa room.

LTCH Inspector #593 observed on June 11, 2014 an unlabelled ladies shaver, disposable razor, deodorant and toothbrush in room E164 and two toothbrushes unlabelled in room P269.

LTCH Inspector #117 and LTCH Inspector #593 on June 16, 2014 in the shared bathroom between rooms P261 and P262, observed no personal care basket on the counter for the resident in room P261. Noted a basket on the counter for P262 however both the basket and the products in the basket were not labelled.

During an interview with LTCH Inspector #117 on June 16, 2014, personal support worker, Staff #129, stated that all resident products are to be kept in a basket on the bathroom counter and the basket is to be labelled with the resident's name. All brushes and combs are supposed to be labelled however toothbrushes are not required to be labelled because the water causes the labelling to come off.

The Manager of Personal Care stated during an interview with LTCH Inspector #117 and LTCH Inspector #593 on June 12, 2014 that previously the home's practice was to label each item however this practice was reviewed in 2012. The policy was changed to include each resident being provided with a basket upon admission, the basket is to be labelled with the resident's name and the resident's personal belongings are to be kept in the basket.

The home's policy on Cleaning of Resident Care Equipment - # 845.01 was reviewed however the policy does not address resident personal items in shared bathrooms nor does it address labelling of resident personal items. [s. 37. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 49 (2)., in that every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #001 mobilizes in a wheelchair with a lap belt applied as a restraint as the resident has been identified as high falls risk. The resident has experienced 5 falls in a period of 6 days. No injuries were sustained in each of the falls and no hospitalization was required.

A review of the resident's progress notes found on a specified day in April 2014, the resident was found on the floor in his/her room following an unwitnessed fall. The resident was holding items in his/her hands and was unable to wheel himself/herself properly and slid from the wheelchair to the floor. Both a Huddle form and a Resident Assessment for Falls Tool (RAFT) form were completed by the on duty registered nurse. Resident was assessed as high risk for falls.

A review of the resident's progress notes found that two days after the fall noted above the resident was found on the floor in his/her room following an unwitnessed fall. Resident advised that s/he was attempting to transfer to bed. No required post-fall forms were completed.

A review of the resident's progress notes found that three days after the first fall noted above the resident was found on the floor in his/her room following an unwitnessed fall. Resident was trying to transfer himself/herself to bed and slid to the floor. A Huddle form was completed by the on shift Registered Nurse.

A review of the resident's progress notes found that four days after the first fall noted above that the resident was found on the floor following an unwitnessed fall. Resident

advised s/he was trying to get to bed from his/her wheelchair and fell onto his/her bottom. A Huddle form was completed by the on shift Registered Nurse.

A review of the resident's progress notes found that five days after the first fall the resident was found on the floor following an unwitnessed fall. Resident advised s/he was trying to reach for something but couldn't and decided to remove stand up but did not apply the brakes to the wheelchair and slid to the floor. No required post-fall forms were completed.

On June 18, 2014, LTCH Inspector #593 reviewed the homes falls prevention policy which states that the registered nursing staff will complete the huddle form on the shift when the fall occurred and that the registered nursing staff will complete the RAFT if the resident has more than two falls in a one week (7 day) period.

On June 18, 2014 during an interview with a registered nurse, Staff #107 and the Manager of Personal Care confirmed to LTCH Inspector #117 and LTCH Inspector #593 the home's policy regarding required forms post falls and that in the previous described events for the resident, a RAFT should have been completed post falls on April 22, 23, 24, and 25, 2014. A such, the long term care home has failed to assess Resident #001 with a clinically appropriate post-fall assessment when the resident sustained four falls on four consecutive days in April 2014.

(O-000338-14) [s. 49. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s. 50 (2) (b) (iv) in that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was not reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #001 is identified as having recurrent pressure ulcers and is at risk for skin breakdown. The current plan of care indicates the resident's skin integrity routine.

On June 17, 2014, registered practical nurse, Staff #130, stated to LTCH Inspectors #117 and #593 that Resident #001's pressure ulcer was cared for that day. Staff #130 stated that the resident currently has altered skin integrity issues including a pressure ulcer.

A review of the resident's chart was done with Staff #130. The following information was noted to be related to the resident's skin and or wound assessments:

-Assessment completed on a day in March 2014. No further information was found in the progress notes, Treatment Administration Record (TAR) or nursing communication book related to the resident's wound status and monitoring of the resident's skin integrity for another 28 days.

-Assessment completed on a day in April 2014. No further information was found in

the progress notes, Treatment Administration Record (TAR) or nursing communication book related to the resident's wound status and monitoring of the resident's skin integrity for no monitoring for another 15 days.

-Assessment completed on a day in June 2014. No further information was found in the progress notes, Treatment Administration Record (TAR) or nursing communication book related to the resident's wound status and monitoring of the resident's skin integrity for another 13 days.

On June 17, 2014, registered nurse, Staff #107, registered practical nurse, Staff #130, stated to LTCH Inspector #117 and LTCH Inspector #593 that Resident #001 does have ongoing skin breakdown issues and that registered nursing staff need to provide care as per the plan of care. The Staff #107 and Staff #130 stated that it is the home's policy to ensure that any assessment, monitoring and provision of wound care be documented in the resident's health care record. They could not confirm if the resident's skin and wound was assessed, monitored and the dressing changed between March 20 to April 17, between April 30 and May 15 and finally between June 4 to June 17, 2014.

(log O-000338-14) [s. 50. (2) (b) (iv)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s. 71(4), whereby the licensee did not ensure that the planned menu items are offered and available at each meal.

On June 16, 2014, LTCH Inspector #148 observed the lunch meal service on a unit.

The planned menu for puree texture indicated that puree snap pea salad and puree brussels sprouts would be prepared. At the meal service, LTCH Inspector #148 confirmed that the puree snap pea salad was prepared and offered to residents; however, puree brussels sprouts were not available or offered to residents as per the planned menu. The food service worker, Staff #140, responsible for serving the lunch meal on the unit, indicated that if a resident did not want the puree snap pea salad that the second choice would be the trepuree macaroni and cheese with tomato. There was no option for a second choice vegetable if a resident choose to have the puree chicken sandwich. Resident #782, who requires a puree texture did not have a second choice of vegetable available as this resident is intolerant of tomato. [s. 71. (3) (b)]

2. The licensee failed to comply with O. Reg 79/10, s.71 (3) (b), whereby the licensee did not ensure that each resident is offered a minimum of a between-meal beverage in the morning.

On June 13, 2014, in the Pine house kitchen, one fluid cart was observed to be prepared by the food service worker, Staff #141. Staff #141 reported to LTCH Inspector #148 that the one beverage cart would be taken by one of the nursing staff members who would offer fluids to the residents of both the east and west side. At approximately 10:20am, the beverage cart was obtained by a personal support worker on the east side, LTCH Inspector #148 observed all residents on the east side of Pine house to be offered a beverage. Upon completion of the east side, the personal support worker returned the beverage cart to the Pine kitchen at which time Staff #141 dismantled the cart. The beverage cart was not observed to be provided to the west side of Pine house. LTCH Inspector #148 spoke with personal support worker, Staff #129, working on the west side of Pine, who indicated that dietary staff are responsible for the beverage cart and that nursing staff members do not offer fluids to residents in the morning.

On June 16, 2014 in the Pine house kitchen, two beverage carts were observed to be prepared. At approximately 10:40am the food service worker, Staff #140, was observed by LTCH Inspector #593 to proceed to the west dining/lounge area with a beverage cart. Staff #140 offered fluids to 2 out of the 5 residents seated in the west dining/lounge area. Staff #140 then proceeded to the east dining/lounge area whereby 2 out of 4 residents were offered a fluid. The fluid cart was then taken to the kitchen and both fluid carts were dismantled. LTCH Inspector #148 interviewed Staff #140 who indicated that she is to only serve independent residents seated in the

dining/lounge areas of the east and west side. Staff #140 further reported that it is the personal support workers' responsibility to serve the residents who require assistance and to take the fluid carts down the hallway to those residents in their rooms. LTCH Inspector #148 spoke with a personal support worker, Staff #107, who reported that the personal support workers do not provide the morning fluid pass and that the fluid pass is provided by the dietary staff.

On June 16, 2014, LTCH Inspector #148 interviewed the home's Food Service Supervisor, who indicated that the morning beverage pass is a shared responsibility between the dietary and nursing staff. She further noted that the afternoon and evening nourishment pass is solely the responsibility of the nursing staff members on the unit.

Observations demonstrate that not all residents were offered a morning fluid pass on Pine house on June 13, 2014 and June 16, 2014. [s. 71. (4)]

WN #10: 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,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. s. 90 (2) (b) in that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment.

During Stage 1 of the RQI on June 9,10,11 and 12, 2014 , it was observed and noted by LTCH Inspectors #138,#117, #543, #593, #599, that in several resident bathrooms on Pine, Elm, Maple, and Willow houses and the Bungalows, open toilet paper rolls were found to be on resident bathroom floors, the back of the toilet tanks and on bathroom counters.

On June 12, 2014, LTCH Inspector #117 spoke with the Manager of Personal Care, the home's lead for the infection prevention and control program. The Manager of Personal Care stated that staff are not supposed to leave open toilet paper on bathroom counters, floors or on the back of the toilet tanks as this was not sanitary and contrary to home's infection control practices.

On June 16, 2014, LTCH Inspector #117 and LTCH Inspector #593 examined resident rooms on Pine, Maple and Elm houses. It was noted that there were no toilet paper holders in the following resident bathrooms Pine #261, #262, #267; Elm #120, Maple # 220, # 216, #251, #270. Open toilet paper rolls were observed to be on bathroom counters and the toilet tanks. Housekeeping staff members Staff #149 and Staff #150 stated to LTCH Inspector #117 that they had not been reporting any missing toilet paper holders to the home's maintenance department. They stated that they thought that missing holders were part of residents care plan and that is why they are leaving toilet paper rolls on counters or the backs of the toilet.

On June 18, 2014, LTCH Inspector #117 and LTCH Inspector #593 spoke with the home's Manager of Hospitality who stated that the home's housekeeping staff are aware of the need to report any equipment requiring repairs, this includes broken or missing toilet paper holders. The manager of Hospitality stated that he was aware that some broken missing toilet paper holders being reported to maintenance for repairs. A review of the home's maintenance and repair logs was done by LTCH Inspector #117 and LTCH Inspector #593 with the home's Facilities Supervisor on June 18, 2014. From January 1, 2014 to June 18, 2014, only three incidents of broken or missing toilet paper holders were reported by staff for repairs. The three identified rooms holders were repaired. However none of the inspector identified resident bathrooms were rooms reported as requiring repairs.

The home did not ensure that resident bathroom equipment, specifically toilet paper holders, are not kept in good repair. [s. 90. (2) (b)]

2. The licensee failed to comply with O. Reg 79/10 s. 90. (2) (b) that the licensee failed to ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids are kept in good repair, excluding residents' personal aids or equipment.

While LTCH Inspector #138 and LTCH Inspector #599 were completing an audit of the call bell system in resident washrooms, it was noted by LTCH Inspector #599 that the

pillows on the bed in room 301 in the Bungalows were not covered by pillow cases and were observed to be in a poor state. Specifically, the pillows were comprised of an impermeable fabric outer layer that had multiple cracks in the fabric which made the impermeable fabric porous and rough. Both inspectors conducted an audit of pillows in the Bungalows, auditing seventeen pillows provided by the home. Of the seventeen pillows audited, ten pillows were observed to have multiple cracks in the impermeable outer fabric layer making the fabric porous and rough.

LTCH Inspector #138 spoke with the unit housekeeping aide, Staff #136, who stated that resident rooms are deep cleaned once a week by housekeeping and that resident pillows are replaced as needed. Staff #102, a personal support worker, stated to the inspector that nursing staff will obtain pillows from housekeeping as needed.

On June 16, 2014, LTCH Inspector #138 spoke with the Manager of Hospitality regarding the replacement of pillows. The Manager of Hospitality stated that there was no formal process to replace resident pillows but stated that pillows could be audited when housekeeping staff clean resident rooms on a weekly basis.

LTCH Inspector #138 spoke with the Manager of Resident Care about the condition of the resident pillows supplied by the home. The Manager of Resident Care stated that it was not desirable to have the pillows in the condition described above and further stated that there was no process in place to ensure that the pillows were in good condition. [s. 90. (2) (b)]

3. The licensee failed to comply with O. Reg 79/10 s. 90. (2) (b) that the licensee failed to ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids are kept in good repair, excluding residents' personal aids or equipment.

On June 10, 2014, during Stage 1 of the RQI, it was observed by LTCH Inspector #548 on Willow house when verifying the call bell system that a call bell pager carried by Staff #157 was not signaling a call from resident room 101 at approximately 12:20pm. The inspector noted that a light at the call bell station in the resident's room was functioning and that the light outside the resident's door was flashing indicating that the call bell had been engaged. The inspector continued to verify the call bell system and noted that at 12:25pm, there was no response from the same pager for resident room 103. Again, the inspector noted that a light at the call bell station in the resident's room was functioning and that the light outside the door was flashing

indicating that call bell had been engaged. The same was observed for room 114 by the inspector at approximately 1:14pm. For all three rooms, the call bell pager was signaled when the call bell station in each of the resident washrooms was activated but did not signal when the call bell was engaged in the resident rooms.

LTCH Inspector #548 spoke with Staff #157 regarding the call bell pager that was not registering calls from resident rooms 101, 103, and 114. The staff member stated to the inspector that he had the call pager since the beginning of his shift at 7:00pm that day and had not identified any concerns with the call bell pager.

LTCH Inspector #138 proceeded to Willow house on June 16, 2014 and tested the call bell pagers. No issues were identified but it was noted that Staff #137 commented to the inspector that the call bell pagers were new. LTCH Inspector also spoke with Staff #158 on Willows house about the call bell system and Staff #158 stated that staff use the call bell pager as the primary piece of equipment to identify a resident's call for assistance. The staff member stated that a light will also illuminate outside the resident's room but that this light is not always visible to staff and is less relied upon.

LTCH Inspector #138 spoke with the Manager of Resident Care on June 18 and 19, 2014 regarding the call bell pagers. In these discussions, the Manager of Resident Care stated that each staff member is responsible to verify that at the start of each shift the assigned call bell is functioning by turning on the call bell pager. Staff are then required to sign out the pager. The Manager of Resident Care further stated that the home does not have any other procedure to ensure that at the call bell pagers are functioning properly, further stating that staff are to report a problem with a call bell pager once it has been identified. LTCH Inspector #138 discussed with the Manager of Resident Care that the call bell pager identified on Willows during Stage 1 had not been identified as not functioning until tested by a LTCH Inspector. [s. 90. (2) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 123.
Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s. 123 (b) in that the licensee failed to ensure a long-term care home who maintains an emergency drug supply for the home shall ensure that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply. On June 20, 2014, the pharmacist also confirmed that the policy does not address the use nor the the tracking and documentation with respect to drugs in the emergency drug supply room.

On June 17,2014 LTCH Inspector #548 conducted a review of the home's medication management system, including the home's process and procedures for the maintenance of the emergency drug supply for the home.

On June 17, 2014 the inspection was conducted on Maple house in the medication room. It was noted that the document titled: Emergency Drug Box List: Peter D. Clark Centre NH listed the drugs in the emergency drug supply. During the review of the emergency storage supply, it was determined that the medication count was incorrect based upon the supply list provided by the home. There was a surplus in the quantity for a number of the medications listed. It was noted that the list posted in the medication room for the drug supply is not dated or signed. In addition, it is noted that there was no documentation for the use of the drugs and the tracking and documentation of drugs maintained in the supply.

On June 18, 2014 during an interview the Manager of Resident Care, it was confirmed that the list of emergency drugs supply on the document Emergency Drug Box List: Peter D. Clark Centre NH is accurate. Review of the home's policy titled: Emergency Pharmacy Services-EB, Index Number 02-02-10, Last updated: September 1, 2009 does not address the use of drugs in emergency drug supply nor the tracking and documentation with respect to the drugs in the emergency drug supply. [s. 123. (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

s. 136. (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:
1. The date of removal of the drug from the drug storage area. O. Reg. 79/10, s. 136 (4).
2. The name of the resident for whom the drug was prescribed, where applicable. O. Reg. 79/10, s. 136 (4).
3. The prescription number of the drug, where applicable. O. Reg. 79/10, s. 136 (4).
4. The drug's name, strength and quantity. O. Reg. 79/10, s. 136 (4).
5. The reason for destruction. O. Reg. 79/10, s. 136 (4).
6. The date when the drug was destroyed. O. Reg. 79/10, s. 136 (4).
7. The names of the members of the team who destroyed the drug. O. Reg. 79/10, s. 136 (4).
8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).

Findings/Faits saillants :

1. The Licensee has failed to comply with O.Reg 79/10, s.136. (3) (b) in that the licensee failed to ensure that drugs must be destroyed by a team acting together and composed of (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) one other staff member appointed by the Director of Nursing and Personal Care. Specifically, the licensee failed to ensure that non-controlled substances are destroyed by a team acting together and composed of members as described by this section.

On June 17, 2014 LTCH Inspector #548 conducted a review of the home's medication management system, including the home's process and procedures for the destruction and disposal of medication for controlled and non-controlled substances.

On June 17, 2014 during an interview with registered nursing staff, Staff #111 and Staff #151, both indicate that the disposal of non-controlled substances include the documentation of the removal of the non-controlled substance from circulation and then place the non-controlled substance in the appropriate medication disposal containers. Both registered nursing staff members indicated that there are two separate containers for the disposal; one container for controlled substances and another container for non-controlled substance.

On June 17, 2014 both registered nursing staff, Staff #111 and Staff #151, both reported that non-controlled substances in their original packaging are placed in the medication disposal container until its removal from the unit.

On June 17, 2014 both medication disposal containers were observed by LTCH Inspector #548 and could not be opened nor manipulated.

On June 18, 2014 during an interview the Manager of Resident Care indicated that the pharmacy provider and the home are involved in the home's medication management system. The process for the destruction of non-controlled substances includes the identification to remove the non-controlled substance from circulation, documentation of its removal by two registered nursing staff members and the non-controlled substance in its original form is placed in the medication disposal container. The container is removed from the home for offsite incineration by the home's pharmacy provider. Further, the Manager of Resident Care indicated she was not aware that team acting together as per O. Reg 79/10 section 136 was a requirement for the destruction of non-controlled substances.

During an interview on June 19, 2014 the home's pharmacist indicated that he was not aware that there was a requirement for a team to act together according to O.Reg 79/10 section 136 in the destruction and denaturing of non-controlled substances. The pharmacist indicated that the current practice is for an outside vendor to come to the home and remove the medication disposal container containing non-controlled substances that have not been destroyed or denatured. The vendor is then responsible to incinerate the disposed non-controlled substances. [s. 136. (3) (b)]

2. The licensee has failed to comply with O.Reg 79/10, s.136. (4)in that the licensee failed to ensure that where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the

persons referred to in clause (3) (a) shall document the following in the drug record:
3. The prescription number of the drug, where applicable.
4. The drug's name, strength and quantity.
6. The date when the drug was destroyed.
7. The names of the members of the team who destroyed the drug.
Specifically, the licensee failed to ensure the appropriate documentation of destroyed narcotics and controlled substances.

On June 17, 2014, LTCH Inspector #548 conducted a review of the home's medication management system, including the home's processes and procedures for the destruction and disposal of controlled and non-controlled substances.

Upon record review it is noted that the destruction of Fentanyl patches is documented on a form titled: Narcotic and Controlled Drug Administration Record. It is noted that there are several instances for June 2014 where the prescription number of the drug, the drug's strength and quantity, the date the drug was destroyed, and the names of the members of the team who destroyed the drug are missing. [s. 136. (4)]

WN #13: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 229 (10) (1) in that each resident admitted to the home was not screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

A review of the home's tuberculosis screening process was conducted as part of the

RQI. The Manager of Personal Care informed LTCH Inspector #117 and LTCH Inspector #593 that the home follows the Ottawa Public Health Unit guidelines for tuberculosis screening, which is doing a Mantoux Tuberculin Skin Test within 14 days of residents' admission to the home.

LTCH Inspector #117 and LTCH Inspector #593 reviewed nine resident health care records for tuberculosis screening. Six residents were noted not to have been screened within 14 days of admission.

• Resident #002 was admitted to the home in March 2014. Tuberculosis screening was not done until 31 days post admission.
• Resident #003 was admitted to the home in March 2014. No information was found in the resident's chart related to tuberculosis screening.
• Resident #004 was admitted to the home in May 2014. Tuberculosis screening was not done until 38 days post admission.
• Resident #005 was admitted to the home in May 2014. One part of the tuberculosis screening was done 14 days post admission. The second part of the screening had not been completed as of June 19, 2014.
• Resident #006 was admitted to the home in April 2014. No information was found in the resident's chart related to tuberculosis screening.
• Resident #007 was admitted to the home in October 2013. No information was found in the resident's chart related to tuberculosis screening.

On June 19, 2014, a registered nurse, Staff #161, stated to LTCH Inspector #117 and LTCH Inspector #593 that Residents #003, #006 and #007 were admitted to the home from a regional hospital. The staff confirmed that the tuberculosis screening had not been done for any of these residents due to their responsive behaviours . Staff #161 stated that hospital screening or past historical information was not brought forward and identified in the residents chart. Residents #003, #006 and #007 health care records document that these residents have ongoing responsive behaviours and that no attempt was made to ensure tuberculosis screening for these three residents.

On June 19, 2014, a registered nurse, Staff #115, stated to LTCH Inspectors #117 and LTCH Inspector #593 that Resident #004 was admitted to the home from a regional hospital. Staff #115 confirmed that the resident had not been screened for tuberculosis since admission due to behavioural issues. The staff member also stated that hospital screening or past historical information was not brought forward and

identified in the resident's chart due to resident behaviours. No information was found in Resident #004's health care records related to staff trying to do tuberculosis screening prior of June 12, 2014.

On June 19, 2014, Staff #115 stated to LTCH Inspectors #117and LTCH Inspector #593 that Resident #005 was admitted to the home from the community. Staff #115 confirmed that the resident had not been screened for tuberculosis since admission due to behavioural issues. Staff #115 also stated that past historical information was not brought forward and identified in the resident's chart due to resident behaviours. No information was found in Resident #005's health care records related to staff trying to do tuberculosis screening prior of June 12, 2014 and no identification of responsive behaviours related to this was noted in the resident's chart.

On June 19, 2014, the home's Manager of Resident Care stated to LTCH Inspector #117 that it is the home's policy to ensure that all residents are screened for tuberculosis within 14 days of admission. If residents are unable to have the Mantoux Tuberculin Skin Test done, for any reason which also includes responsive behaviours, then staff need to verify if there is any historical information or information from regional hospitals related to tuberculosis screening. This information needs to be identified in the residents' chart. If there is no hospital or historical information readily available, nursing staff are to notify the attending physician for the next directives in tuberculosis screening.

The home failed to ensure that residents newly admitted to the home are screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. [s. 229. (10) 1.]

Issued on this 25th day of June, 2014

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

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) :	PAULA MACDONALD (138), AMANDA NIXON (148), LYNE DUCHESNE (117), RUZICA SUBOTIC-HOWELL (548)
Inspection No. / No de l'inspection :	2014_362138_0009
Log No. / Registre no:	O-000497-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 25, 2014
Licensee / Titulaire de permis :	CITY OF OTTAWA Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6
LTC Home / Foyer de SLD :	PETER D. CLARK CENTRE 9 MERIDIAN PLACE, OTTAWA, ON, K2G-6P8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	NOREEN LANGDON

To CITY OF OTTAWA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee is required to ensure that the home is equipped with a resident-staff communication and response system in resident washrooms that can be accessed and used by all residents.

Grounds / Motifs :

1. The licensee failed to comply with O.Reg 79/10 s. 17. (1) (a) in that the licensee of a long-term care home failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

It was determined that the home uses a resident-staff communication system commonly referred to as a call bell system in which a person in any resident's room can send a signal for assistance by engaging a button on a cord attached to a call bell station or, in the resident's washroom, can pull a call bell pull cord that engages the pull station of a call bell to send a signal. The signal for the call bell system once engaged is a light that is activate outside the door of the resident's room, a page to a pager carried by a staff member indicating the room and location (room or washroom) where the signal originated, and an audible

alarm along with location display on a panel at the nursing station.

During Stage 1 of the Resident Quality Inspection (RQI) conducted June 10, 11, and 12, 2014, it was noted by Long Term Care Homes (LTCH) Inspector #138 that the call bell pull cord in resident washrooms in the Bungalows rooms 103, 109, 112, 301, 302, 307, 403, 405, and 409 was made from a white string like material that were short, measuring not more than eight inches in length, and were not long enough to be able to be attached to the grab bar near the toilet or placed with a resident sitting on the toilet. It was also noted by the inspector that the call bell station and pull cord in these identified washrooms were located on the same wall as the toilet and in such a way that it would necessitate a resident who was sitting on the toilet to reach behind and stretch in order to even potentially reach the call bell pull cord. In most cases, due to size, residents would not be able to reach the call bell pull cord, thus the call bell pull cord would not be accessible to residents.

LTCH Inspector #117 also observed during Stage 1 of the RQI on Maple and Elm houses that there were pull cords in resident washrooms that were not accessible to residents for a variety of reasons. Specifically, it was noted in Elm house in room 104 and 154 and that the call bell pull cords were a red plastic-like material that were short, could not be placed on the grab bar, and could not be reached by a resident sitting on the toilet. Further, it was noted by the same inspector on Maple house room 210 that the call bell pull cord, which was made of a red plastic-like material, was pinned to the wall with a metal bracket that prevented it from being given to a resident seated on the toilet. This pull cord was also out of reach of a resident who would be seated on the toilet. In room 253 on Maple house, it was noted by the inspector that the call bell pull cord was long enough to reach a resident seated on the toilet but that the pull cord had been pinned to the wall with a metal bracket. It was noted that the metal bracket provided enough resistance to prevent the red, plastic-like material pull cord from engaging the call bell when it was pulled.

LTCH Inspector #599 observed on Pine house during Stage 1 of the RQI that the resident washroom in room 215 had a call bell pull cord that was a red, plastic-like material, that was short and would not reach the resident while seated on the toilet, and that it was out of reach of a resident who would be seated on the toilet.

On June 13, 2014, LTCH Inspector #138 spoke with a registered nurse on the

Bungalows, Staff #115, regarding the length of the call bell pull cords in the resident washrooms, specifically in the Bungalows. Staff #115 stated that all the pull cords in the resident washrooms in the Bungalows (the Bungalows houses 48 resident beds) are short and that it was believed that they were shortened for potential resident safety reasons a long time ago.

On June 13, 2014, LTCH Inspector #138 spoke with maintenance staff, Staff #148, who was in the Bungalows conducting maintenance work. The inspector asked about the length of the call bell pull cords and Staff #128 stated that he believed that some of the pull cords had been broken over the years and then made shorter both as a maintenance/housekeeping issue as well as a resident safety issue. Staff #148 further stated that all pull cords were supposed to have been replaced with a new red, plastic-like product that was stronger and easier to clean. Staff #148 stated he has replaced his assignment of pull cords in the houses about three months ago and was unsure why the pull cords were not replaced in the Bungalows.

On June 13, 2014, LTCH Inspector #138 spoke with the Facilities Supervisor regarding the call bell pull cords in the Bungalows. The Facilities Supervisor stated that the pull cords in the home had previously been made of string that were easily broken and difficult to clean. He further stated that the home's lead for the infection prevention and control program had wanted the call bell pull cords replaced with a red plastic-like product that was stronger and easier to clean. The Facilities Supervisor stated that he opened a work order in September 2013 to have all the call bell pull cords in the home replaced and further stated that the work order was closed in May 2014. The inspector stated that the pull cords in the Bungalows have not been replaced and the Facilities Supervisor stated that he opened a new work order earlier that day after learning from the maintenance staff in the Bungalows that the pull cords had not been replaced as expected.

LTCH Inspector #138 and LTCH Inspector #599 toured the home on June 16, 2014 and verified that the call bell pull cord in the resident washrooms in the Bungalows were not accessible to residents due to their length. While in the Bungalows, LTCH Inspector #138 spoke with Resident #020 who stated that s/he is assisted by staff to the toilet and then left unattended. The resident further stated that s/he is not able to use the call bell in the washroom to request assistance as s/he can not reach the call bell pull cord. The resident further stated s/he is required to wait until staff are ready to assist him/her off the toilet.

The inspectors continued to the houses and verified that the call bell pull cords in resident washrooms in Elm house rooms 104 and 154, Pine house room 215, and Maple house 210 and 253 were the pull cords made of a red plastic-like material and were not accessible as observed in Stage 1.

On June 16, 2014, LTCH Inspector #138 spoke with the Program Manager of Resident Care regarding the call bells pull cords that were observed to be inaccessible to residents in Stage 1. The Program Manager of Resident Care stated that long call bell pull cords were considered a safety risk to residents in the Bungalows and that the replacement of the pull cords through out the home was related to infection prevention. The Program Manager of Resident Care further stated that it was unknown if accessibility of the call bell pull cords was considered when the call bell pull cords were replaced.

On June 16, 2014 LTCH Inspector #138 spoke with the Manager of Personal Care, who is the lead for the home's infection prevention and control program, regarding the replacement of the call bell pull cords. The Manager of Personal Care stated that the call bell pull cords were to be replaced in the home with a new product that was red and that was easier to clean. The Manager of Personal Care stated that he was under the impression that the pull cords were all replaced. The inspector discussed with the manager that the call bell pull cords in the Bungalows had not been replaced and also discussed inaccessibility of the call bell pull cords in the Bungalows as well as the inaccessibility of several call bell pull cords, mentioned above, that had been replaced with the new red, plastic-like material. The Manager of Personal Care stated to the inspector that he would look into the accessibility of the call bell pull cords. (138)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2014

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 : 002

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

Pursuant to / Aux termes de :

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

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

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

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

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

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

Order / Ordre :

The licensee will ensure that:

1. All resident accessible doors that lead to the stairways and doors that lead to the outside of the home, are equipped with an audible door alarm that allows calls to be canceled only at the point of activation and, A. is connected to the resident-staff communication and response system, or B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

2. All doors leading to non-residential areas are equipped with a lock and are kept closed and locked when the area is not immediately supervised, in order to restrict unsupervised access to those areas by residents.

3. A plan is developed and implemented to ensure resident safety until such time when compliance with section 9 of the Act is achieved.

Grounds / Motifs :

1. The licensee failed to comply with O.Reg 79/10, s.9 (1) 1. (iii), whereby the licensee did not ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access must be equipped with an audible door alarm that allows calls to be canceled only at the point of activation and is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

Peter D. Clark consists of two buildings known as the Houses and the Bungalows. Within the building known as the Houses, there are 4 resident areas (Pine, Elm, Maple and Willow houses). On each house there are two sides (east and west side); on each side there are two doors, one down each hallway, that lead to stairways. Between the four houses, there are a total of 16 doors that are accessible to residents that lead to stairways. Each door leading to a stairway was observed to be kept closed and locked and is equipped with a door access control system that is kept on at all times.

On June 13, 2014, LTCH Inspector #148, in the company of the home's Facility Supervisor, observed the doors leading to stairways on the Elm and Willow houses. The eight doors leading to stairways were observed to have no audible

door alarm. Each door was opened using the home's access key card which unlocks the door access control system. The door was then held open at which time a signal was received by the resident-staff communication system and the audio visual enunciator at the nearest nursing station. No audible door alarm occurred at the point of activation. It was further noted, in the presence of both the Charge Registered Nurse, Staff #133 and the Facilities Supervisor that the signal sent to the enunciator could be canceled at the enunciator by lifting and hanging up the receiver attached to the enunciator. Observations confirmed that the signal activated at the stairway doors could be canceled at the nursing station enunciator and that the stairway door did not have a manual reset switch at the door. It was noted that within four of the eight stairways observed, that there was a door leading to an unsecured outside area, this door is not locked.

The main entrance/exit of the building known as the Houses consists of two sets of sliding doors that lead to the outside of the home. When exiting the building a person would first exit through the inner sliding door by using an access key card, once past the inner door the outer sliding door will open by motion detection. Both doors are equipped with a door access control system that is on at all times, the inner sliding door is kept closed and locked and is accessible to residents. On June 13, 2014, the main entrance/exit was observed with the Facilities Supervisor at which time it was confirmed that neither the inner or outer door is equipped with an audible door alarm. It was further confirmed that no alarm, associated with the main entrance/exit, is connected to the resident-staff communication system or to an audio visual enunciator that is connected to the nearest nursing station.

The main entrance/exit of the building known as the Bungalows, consists of two sets of double doors that lead to the outside of the home. When leaving the resident's main living area to exit the home, a person would first need to exit though a set of locked double doors which lead to a foyer. Within the foyer there is a seating area, office space, conference room, a door leading to non-residential space and the main entrance/exit of the home. A person may also access the foyer through the nursing station, which includes two separate unlocked doors that connect the resident's living area to the foyer. During this inspection, observations of the vestibule including the presence of the WatchMate system at the main entrance/exit and observations of residents using the main entrance to enter and exit the building assist to define the vestibule as resident accessible. On June 16, 2014, LTCH Inspector #148 observed the main entrance/exit doors of the Bungalows. The outer double

doors are kept closed but are unlocked and not equipped with a door access control system. The inner double door is kept closed and locked and is equipped with a door access control system that is kept on at all times. During the observation it was confirmed that the inner door does not have an audible door alarm and no alarm, associated with this entrance/exit, is connected to the resident-staff communication system or to an audio visual enunciator that is connected to the nearest nursing station. This was confirmed with the registered nursing staff, Staff #113.

Within the Bungalows, located between the inner and outer double doors of the main entrance/exit, there is a door leading to a stairway. The door is kept closed and locked and is equipped with a door access control system that is kept on at all times. On June 16, 2014, LTCH Inspector #148 observed the door to not be equipped with an audible door alarm nor was an alarm, connected to the resident-staff communication system or to an audio visual enunciator that is connected to the nearest nursing station.

The above observations of June 13 and June 16, 2014 were reviewed and confirmed with both the home's Administrator, Manager of Resident Care, Facilities Supervisor and the Manager of Recreation Leisure and Volunteer Services . (148)

2. The licensee failed to comply with O.Reg 9 (1) 2., whereby 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.

The clean and soiled utility rooms for each house (Pine, Maple, Elm and Willow) are located in an alcove on each side (east and west) of the unit. Each house has a total of four utility rooms, two on each side. On June 12, 2014, at 8:45am, LTCH Inspector #148 observed the clean and soiled utility rooms on the west side of Pine house. The doors leading to the clean and soiled utility rooms were observed closed and each door was equipped with a lock. The utility rooms are located in an alcove, and at the time of the observation were not supervised by staff. Both the clean and soiled utility doors were observation to be closed and unlocked. Housekeeping staff member, Staff #117, was working one hallway and when asked by the inspector, indicated that these rooms are used by the nursing staff members. Staff #117, was not sure if the doors should be locked but proceeded to lock the doors. LTCH Inspector #148 informed nursing staff on

the unit of the unlocked utility doors.

On June 12, 2014, at 8:55am LTCH Inspector #148 observed the utility room doors on the west side of Pine house. The doors leading to the soiled and clean utility rooms were observed to be closed and each door was equipped with a lock. The doors are located in an alcove and at the time of the observation were not supervised by staff. Both the clean and soiled utility doors were observed to be closed and unlocked. The inspector spoke with a personal support worker, Staff #105, who indicated that residents do not use the two utility rooms, but occasionally family will access the rooms. Staff #105 indicated that the doors may have been unlocked by the evening or night staff, as he recalls the doors to be locked at the end of the day shift yesterday. Staff #105 informed the registered nurse, Staff #107, of the unlocked doors. Staff #105 then proceed to lock both utility doors.

The home's Administrator identified the Manager of Recreation, Leisure and Volunteer Services or the Facilities Supervisor to be an appropriate manager to tour the home related to door security and safety. (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 22, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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 25th day of June, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PAULA MACDONALD

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