Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 4, 2015	2015_365194_0005	O-001671-15	Resident Quality Inspection

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

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

PLEASANT MEADOW MANOR
99 Alma Street P. O. Box 426 Norwood ON K0L 2V0

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

CHANTAL LAFRENIERE (194), AMBER MOASE (541), KELLY BURNS (554), LYNDA BROWN (111), RENA BOWEN (549), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 18, 19, 20, 23, 24, 25 and 26, 2015

Also inspected in the inspection four Critical Incident Logs#O-00696-14,#O-00698-14, #O-00699-14 and # O-00700-14

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Residents, Families, Registered Nurse (RN),Registered Practical Nurse(RPN), Personal Support Worker (PSW), Physiotherapist(PT),Life Enrichment Coordinator (LEC), Environmental Service Manager (ESM), Maintenance Manager, Housekeeping staff, Office Manager and Clinical Care Coordinator/RAI Nurse

Also inspected in the course of the inspection was provision of staff/resident care, observation of dining services, medication administration, infection control practices, review of Maintenance records, Falls Prevention, Abuse prevention, Restraint, Complaints and Concern Programs. Reviewed Staff educational records, internal incident reports, Internal abuse investigations, Complaint logs, Resident Council Minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **5 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (a), by ensuring that the home, furnishings and equipment are kept clean and sanitary.

The following observations were made during the dates of February 18, through to February 20, 2015:

- Flooring – dark staining, with visible dust and debris note along flooring baseboard, especially in corners of resident room/washroom(s) Asphodel Hallway #102, 103, 104, 105, 106, 108, 112, 115; Norwood Hallway #203, 205, 206, 207, 209, 215; and along threshold in both Norwood and Asphodel halls (Note: dark staining, dust and debris in some areas are easily removable when scraped with a pen)

Housekeeping Staff #105 indicated that resident rooms and washrooms are dry mopped and washed daily but the dark staining in corners and along walls is impossible to remove.

Environmental Service Manager indicated awareness of the dark staining along the wall baseboards and corners in resident rooms and hallways stating the areas are due to wax build up. ESM indicated that housekeeping staff or an external contracted service (floor cleaner) does go around the home twice a year to thoroughly clean these areas. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the dates of February 18, through to February 20, 2015:

- Bathroom Entry – missing threshold in Asphodel Hallway room #103; sub-flooring is exposed. (Note: uneven flooring poses a potential trip/falls hazard for residents) (Noted in maintenance log book dated Dec. 09, 2014)

- Flooring – laminate flooring or tiled floors noted to be chipped, cracked, split or pulling away from the wall in room(s) located in Asphodel Hallway #102 (near window), 103 (near D bed), 104 (under baseboard heater), 105 (in front of A bed), 106 (under

baseboard heater), 110 (in front of bed A), 110 (under baseboard heater), 112 (under baseboard heater), 117; in several areas throughout Asphodel hallway; in the main dining room by the emergency fire exit/patio area; and in both tub/shower rooms (Note: uneven flooring poses a potential trip/falls hazard for residents)

- Flooring – laminate or Gera-floor- dark staining in front of toilet and or sink (walking path) – in resident washroom(s) located on Asphodel Hall # 104, 105, 106, 110; Norwood Hall #203, 204, 212 (yellow/rust coloured stains) and also throughout the tub/shower room located in the Asphodel hall

- Fire Door Mechanism – the metal cover is missing from the door mechanism mounted above resident door located in Asphodel Hallway #103. Electrical wiring is exposed. (Noted in maintenance log book, dated Dec. 09, 2014)

- Doors – in resident rooms and washrooms are scraped or have deep gouges in the wood finish – located in room(s) on Asphodel Hallway #102, 105, 106, 110; Norwood Hallway #201, 203, 209, 215; Door Frame - Asphodel tub shower room, is chipped and has paint missing in areas.

- Sink Vanity or Countertop – laminate lifting or missing from sink vanity in resident washroom(s) located on Asphodel Hallway #102, 106 (jagged edges), 107; Norwood Hallway #210; in the activity room and in the main dining room (Note: surface is porous and poses a potential infection control issue as difficult to clean)

- Sinks – sealant or caulking is missing or cracked – dark staining to surround area ; in resident washroom(s) located on Asphodel Hall #104, 107; Norwood Hall #202, #203 (Note: room 107, noted in maintenance log book dated Dec. 09, 2014)

- Toilet(s) – dark brown/black staining around base of toilet and flooring in washroom(s) located in Asphodel Hallway #100, 102, 103, 104, 105, 107, 108, 110, 112; Norwood Hallway #201, 202, 203, 205, 207, 208, 209, 210 Tub/Shower room on both Asphodel and Norwood (note: room 207 noted in maintenance log book dated Jan. 06, 2015)

- Walls – nail, hook or screw holes visible – in resident room(s) located on Asphodel Hall #105, 106, 108

- Walls – scuffed (black marks) with paint chipping in areas – in room(s) located in Asphodel Hall #100 (crack in wall by window), 106, 112 (wall cracked under window);

Norwood Hall #201 (wall cracked under window), 202 (gouge in wall in wall at room entry, as well as crack in wall under the window), 203 (wall cracked under window), 206, 211, 215 ; in the Asphodel tub/shower room and in Asphodel lounge (also has area of wall damage, hole in wall to the left of heater/vent in this room)

- Wall or Baseboard Guard – missing or loose – in room(s) located on Asphodel Hallway #102 (is missing jagged drywall and steel corner underneath is exposed), 117; Norwood Hallway #207; and in the Asphodel tub/shower room (as well as tile missing as you enter room)

- Baseboard Heater – areas of steel covering heater is bent; finish on baseboard heater is scuffed (black marks) in room(s) located on Asphodel Hall #102, 106; Norwood Hall #206

- Lighting – pot light at door entry is burnt out or not functioning – resident room(s) located on Asphodel Hall #104, 105; Norwood Hall #210 (Note: light bulb burnt out in room 105 noted in communication book dated Dec. 16, 2014)

- Window – laminate off of window sill in Norwood Hall room #209

- Ceiling – finish on ceiling lifting with paint chipped or cracked in areas, in room(s) located on Asphodel Hall #106, Norwood Hall #205, 207, 209, 212; and in Asphodel lounge

- Resident Wardrobes (closet) – door and hinge on right side is loose or broken, causing door to be difficult to open and close; located in room(s) on Norwood Hall #203 beds A and D (note: closet door bed D mentioned as needing repair on Jan. 29, 2015; maintenance log book indicates 'fixed' – closet door during inspection remains broken)

- Handrails – both Asphodel and Norwood halls are worn, finish lifted or chipped in areas

- Window Frames – in Asphodel lounge – paint chipped and lifting on windows (porous wood finish)

- Carpeting – main foyer (by nursing station and dining room) and Norwood lounge – visible staining in several areas

- Shower Stall – Norwood Hall tub and shower room – flooring cracked in areas

throughout

- Activity Room by exit into courtyard - A sharp, metal clamp (previous fire extinguisher holder)protruding approx. 4 inches from the wall, posing a hazard to residents.

Maintenance Communication Log book was reviewed for the period of December 01, 2014, through to February 18, 2015. A few items listed above were identified by staff as needing repairs.

A review of Preventative Maintenance Checklists for the period of October 2014, through to January 2015, fails to identify areas listed above as needing repair and or replacement.

The home's policy, Preventative Maintenance (OP-MTC-2.1), directs that preventive maintenance shall be conducted monthly in accordance with the monthly preventative maintenance checklist; deficiencies shall be documented and a plan for corrective action developed that addresses any/all deficiencies.

Maintenance Manager indicated that he/she had just been hired by the home and he/she is gradually looking at what needs to be repaired or replaced, but there was no formal documentation as of February 20, 2015 of what repairs needed to be completed. Maintenance Manager indicated some awareness of above issues (ceiling and toilet issues), but did indicate not being aware of other items listed above.

The Administrator/Director of Care indicated there is currently no corrective action in place to address the above deficiencies.

Note: In the 2014 Resident Quality Inspection (#2014_ 365194_0006), dated July 8, 2014 a Voluntary Plan of Correction was issued for LTCHA, 2007 s. 15(2)(c). DOC indicated no Voluntary Plan of Correction was completed for this non compliance. [s. 15. (2) (c)]

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. 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) (e), by ensuring that the home is equipped with a resident-staff communication and response system that is, available in every area accessible by residents.

The following resident areas were observed with no available form of resident-staff communication and response system accessible to residents:

- Activity room across from the Dining room
- Dining room
- Hairdressing room
- Physio Therapy room
- Lounges located at the end of Norwood and Asphodel Hallways. Both lounge areas are presently equipped with "bankers bell screwed to the wall"

Life Enrichment Coordinator indicated that if a resident required assistance when in the activity room, resident would have to wait until staff approached the room or could verbally call for assistance.

Administrator indicated awareness of resident's not having access to a resident staff communication and response system in the above indicated areas. [s. 17. (1) (e)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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 has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On an identified date, the Physiotherapist documented in progress notes that Resident #04 was more active and was able to foot propel and sit upright in the regular type 3 wheelchair. Resident #04 was not sliding out of the regular wheelchair with seat belt in use. If Resident #04's condition declines and become unable to foot propel or sit upright, the resident will be back in the type 5 wheelchair.

On the next day and two other days, Resident #04 was observed by inspector #194 and #570 sliding in the wheelchair with a front buckle seat belt in place. Staff were notified and resident was repositioned.

Six days after change to wheelchair, Resident #04 was observed by inspectors #194 and #570 sliding in the wheelchair with seat belt undone. Staff were notified and resident was repositioned.

On the sixth day during an interview the Physiotherapist indicated that when Resident #04 was assessed the resident was able foot propel, sit upright and undue the seat belt. When the resident declined and started to slide from the regular wheelchair, the resident's wheelchair should have been switched.

On the sixth day during an interview with the DOC and the Clinical Care Coordinator #116 they indicated that the physiotherapist's direction should have been followed and

resident #04's wheelchair switched to the customized seating wheelchair when the resident started to slide from the regular wheelchair. [s. 6. (7)]

2. The licensee has failed to ensure the resident was reassessed and the plan of care revised with the resident's change in condition.

On an identified date the Physiotherapist documented in progress notes that Resident #04 was more active and was able to foot propel and sit upright in her regular type 3 wheelchair. Resident #04 was not sliding out of the regular wheelchair with seat belt in use. The resident is wearing seat belt in that wheelchair but can undo it.

Interview with PSWs staff #113 and #110, four days after seat belt applied, indicated that Resident #04 was able to unfasten the seat belt.

Later on the fourth and fifth day, Resident #04 was observed by inspectors sliding in the wheelchair with a front buckle seat belt in place. Resident was unable to undue seat belt when asked by inspector and PSW staff #113.

Seven days after initial assessment, the Physiotherapist indicated that the seat belt used by Resident #04 is considered as a PASD whether the resident is able unfasten belt or not. The expectation is that registered staff will complete the PASD assessment and monitor the resident.

On the seventh day during an interview with the DOC and the Clinical Care Coordinator staff #116 they indicated that the seat belt used by Resident #04 is considered as a PASD.

Review of the clinical health record for Resident #4 does not identify any assessment after change in condition related to the seat belt not being able to be unfastened by the resident. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that
-the care set out in the plan of care is provided as specified in the plan.
-the resident is reassessed and the plan of care revised when the resident's care needs change., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to log # 000700-14:
A critical incident report received on an identified date for staff to resident verbal and emotional abuse that occurred twelve days before.

Related to log # 000698:
A second critical incident report received on an identified date for an allegation of staff to resident verbal and emotional abuse that occurred twelve days before.

Related to log # 000699:
A third critical incident report received on an identified date for an allegation of staff to resident emotional abuse that occurred twelve days before.

Related to log # 000696:
A fourth critical incident report received on an identified date for an allegation of staff to resident physical and emotional abuse that occurred on twelve days previous

Interview of the Administrator/DOC indicated that the four incidents were reported to the Charge RN on the identified date but the incidents were not reported to the Director until the next day when it was received by the Administrator/DOC.

Interview of PSW#110 indicated that on identified date, PSW #107 reported being slapped by Resident #45 PSW#110 reported the incident to RN #111. PSW #110 indicated that the RN spoke to the resident and was informed that the staff had slapped the resident. PSW #110 completed a incident report as requested.

Interview of RN #111 recalled the shift when PSW#107 had "multiple issues with residents". RN # 111 was the manager in charge of the home on the identified date. The RN completed the incident report for Resident #45 slapping PSW#107 and a witness report for all incidents. The RN denied calling management, the SDM, the Director or the police. The RN indicated not being aware of reporting requirements but did recall receiving training on the homes abuse policy. [s. 24. (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 by ensuring that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM, if any, and any other person specified by the resident are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident

Related to log # 000700-14:
A critical incident report received on an identified date for staff to resident verbal and emotional abuse.

Related to log # 000698:
A second critical incident report received on an identified date for an allegation of staff to resident verbal and emotional abuse.

Related to log # 000699:
A third critical incident report received on an identified date for an allegation of staff to resident emotional abuse.

Related to log # 000696:
A fourth critical incident report received on an identified date for an allegation of staff to resident physical and emotional abuse.

Interview of the Administrator/DOC, review of the residents health record, and review of the home's investigations had no documented evidence that the SDM's were notified of the staff to resident abuse incidents. [s. 97. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the resident's SDM, if any, and any other person specified by the resident are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the documented record (of complaints received) is reviewed and analyzed for trends, at least quarterly. The results of the review and analysis are taken into account in determining what improvements are required in the home, an a written record is kept of each review and of the improvements made.

A review of the complaint binder for 2014 was completed by the inspector. Eight complaints were identified in the binder.
1. Jan 7/14 maintenance issue
2. Feb 8/14 health and safety concern
3. Feb 25/14 maintenance issues
4. April 9/14 service provider concern
5. May 1/14 dietary concern
6. June 21/14 resident safety/maintenance issue
7. June 27/14 provision of care concern
8. Nov 18/14 Dietary concern

DOC has indicated that a review and analysis was not completed for the above at least quarterly. [s. 101. (3)]

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 by ensuring that the documented record (of complaints received) is reviewed and analyzed for trends, at least quarterly. The results of the review and analysis are taken into account in determining what improvements are required in the home, an a written record is kept of each review and of the improvements made., to be implemented voluntarily.

WN #7: 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there a hand-hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

PIDAC directs the placement of Alcohol Based Hand hygiene Rub dispensers: Installing alcohol-based-based hand rub dispensers at the point-of-care improves adherence to hand hygiene.23, 122, 150 Point-of-care is the place where three elements occur together: the client/patient/resident, the health care provider and care or treatment involving client/patient/resident contact. Hand hygiene products available at point-of-care are easily accessible to staff by being as close as possible, i.e., within arm's reach, to where client/patient/resident contact is taking place.

There are 61 residents in this home, with 9 semi private rooms, 10 private rooms and 9 ward rooms. Access to point-of-care hand hygiene agents were found at the home to be in the hallway outside of resident rooms. There was no access to point-of-care hand hygiene agents inside the resident rooms.

Two PSW #114 and #115 indicated that they did not carry personal hand hygiene with them during the provision of resident care. Both PSW's indicated that they used the hand hygiene dispenser located outside the resident's room prior to providing care and if required during care they would go to the resident's bathroom sink to wash their hands and continue with care. After completing care the staff indicated they would use the hand hygiene dispenser located outside the resident's room. [s. 229. (9)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that there a hand-hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Privacy curtains in the following resident rooms were observed to not fully enclose the resident unit (space) thereby not allowing privacy; observations were made during a three day period:

Seven separate resident areas, occupied by more than one resident did not have sufficient privacy curtains to provide privacy.

Resident #31 indicated that when in the smoking area in the court yard, the resident, as well as other residents and visitors can see into other co-resident's rooms when care is being provided; resident indicated bringing this concern forward in the past.

Environmental Services Manager indicated being aware of this concern and stated that new privacy curtains have been requested as part of the 2015 Capital Budget.

Administrator indicated no awareness of the privacy curtains not enclosing the resident bed/unit and then indicated 'privacy curtains must be shrinking when washed'. [s. 13.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 14, by ensuring that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

The following observation was made during the date of February 18, through to February 20, 2015:
In the Asphodel Tub/Shower Room there was no grab bar was visible on same wall as the faucet in the shower stall

Maintenance Manager and the Administrator both indicated no awareness of the shower stall not having a grab bar on the same wall as the faucet of this tub/shower room. [s. 14.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Related to log # 000700-14:
A critical incident report was reported for staff to resident abuse.

Related to log # 000698:
A second critical incident report was reported, for an allegation of staff to resident verbal and emotional abuse.

Related to log # 000696:
A third critical incident report was reported for an alleged staff to resident emotional and physical abuse.

Related to log# 000699:
A fourth critical incident report was reported for an alleged staff to resident emotional abuse.

All four incident were reported to have occurred on the same day.

Interview of Administrator/DOC indicated the police were contacted the following day when she was notified of the incident and stated "the RN should have contacted the police". [s. 98.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101.

Review of the licensee policy related to "Complaints Procedure" AM-6.1 dated November 2010 was completed. The policy does not provide procedures to complete a review and analysis for trends at least quarterly, to use the trends in determining what improvements are required in the home and to keep a written record of each review and the improvements made in the response as directed in O. Reg 79/10 s. 101(3)(a)(b)(c)

DOC has indicated that a review and analysis for trends of the eight documented complaints for 2014 were not completed at least quarterly. [s. 100.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Related to log # 000700-14:
A critical incident report was reported for staff to resident abuse.

Related to log # 000698:
A second critical incident report was reported, for an allegation of staff to resident verbal and emotional abuse.

Related to log # 000696:
A third critical incident report was reported for an alleged staff to resident emotional and physical abuse.

Related to log# 000699:
A fourth critical incident report was reported for an alleged staff to resident emotional abuse.

All four incident were reported to have occurred on the same day.

Interview of the Administrator/DOC indicated the Director was notified by phone on the following day of the staff to resident abuse incidents but the reports were not provided to the Director until 12 days later. [s. 104. (2)]

Issued on this 5th day of March, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194), AMBER MOASE (541), KELLY BURNS (554), LYNDA BROWN (111), RENA BOWEN (549), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2015_365194_0005
Log No. / Registre no:	O-001671-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 4, 2015
Licensee / Titulaire de permis :	OMNI HEALTH CARE LIMITED PARTNERSHIP 1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9
LTC Home / Foyer de SLD :	PLEASANT MEADOW MANOR 99 Alma Street, P. O. Box 426, Norwood, ON, K0L-2V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SANDRA BROW

To OMNI HEALTH CARE LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will prepare, implement, and submit a corrective action plan to ensure that the home, furnishings and equipment are maintained in safe condition and in a good state of repair including:
-repairing, refinishing and/or replacing, as appropriate, all damaged floor surfaces
-repairing and/or replacing, as appropriate, all damaged doors and door frames
-repairing and/or replacing, as appropriate, all damaged sink vanities or counter tops.
-repairing and/or replacing, as appropriate, all damaged handrails.
-repairing and/or replacing, as appropriate, all damaged walls and baseboard heaters.

The licensee will develop and implement a process that clearly identifies areas of disrepair in the home. The process must also include who will be responsible for completing the repairs and the date the repairs were completed.

The licensee will provide a written plan indicate the by March 13, 2015
This plan must be submitted in writing to the MOHLTC, Attention: Chantal Lafreniere,
Fax (613)569-9670.

Grounds / Motifs :

1. Note: In the 2014 Resident Quality Inspection (#2014 365194 0006), dated

July 8, 2014 a Voluntary Plan of Correction was issued for LTCHA, 2007 s. 15(2)(c). DOC indicated no Voluntary Plan of Correction was completed for this non compliance.

- Bathroom Entry – missing threshold in Asphodel Hallway room #103; sub-flooring is exposed. (Note: uneven flooring poses a potential trip/falls hazard for residents) (Noted in maintenance log book dated Dec. 09, 2014)

- Flooring – laminate flooring or tiled floors noted to be chipped, cracked, split or pulling away from the wall in room(s) located in Asphodel Hallway #102 (near window), 103 (near D bed), 104 (under baseboard heater), 105 (in front of A bed), 106 (under baseboard heater), 110 (in front of bed A), 110 (under baseboard heater), 112 (under baseboard heater), 117; in several areas throughout Asphodel hallway; in the main dining room by the emergency fire exit/patio area; and in both tub/shower rooms (Note: uneven flooring poses a potential trip/falls hazard for residents)

- Flooring – laminate or Gera-floor- dark staining in front of toilet and or sink (walking path) – in resident washroom(s) located on Asphodel Hall # 104, 105, 106, 110; Norwood Hall #203, 204, 212 (yellow/rust coloured stains) and also throughout the tub/shower room located in the Asphodel hall

- Doors – in resident rooms and washrooms are scraped or have deep gouges in the wood finish – located in room(s) on Asphodel Hallway #102, 105, 106, 110; Norwood Hallway #201, 203, 209, 215; Door Frame - Asphodel tub shower room, is chipped and has paint missing in areas.

- Sink Vanity or Countertop – laminate lifting or missing from sink vanity in resident washroom(s) located on Asphodel Hallway #102, 106 (jagged edges), 107; Norwood Hallway #210; in the activity room and in the main dining room (Note: surface is porous and poses a potential infection control issue as difficult to clean)

- Walls – nail, hook or screw holes visible – in resident room(s) located on Asphodel Hall #105, 106, 108

- Walls – scuffed (black marks) with paint chipping in areas – in room(s) located in Asphodel Hall #100 (crack in wall by window), 106, 112 (wall cracked under window); Norwood Hall #201 (wall cracked under window), 202 (gouge in wall in

wall at room entry, as well as crack in wall under the window), 203 (wall cracked under window), 206, 211, 215 ; in the Asphodel tub/shower room and in Asphodel lounge (also has area of wall damage, hole in wall to the left of heater/vent in this room)

- Wall or Baseboard Guard – missing or loose – in room(s) located on Asphodel Hallway #102 (is missing jagged drywall and steel corner underneath is exposed), 117; Norwood Hallway #207; and in the Asphodel tub/shower room (as well as tile missing as you enter room)

- Baseboard Heater – areas of steel covering heater is bent; finish on baseboard heater is scuffed (black marks) in room(s) located on Asphodel Hall #102, 106; Norwood Hall #206

- Handrails – both Asphodel and Norwood halls are worn, finish lifted or chipped in areas

- Shower Stall – Norwood Hall tub and shower room – flooring cracked in areas throughout

Maintenance Communication Log book was reviewed for the period of December 01, 2014, through to February 18, 2015. A few items listed above were identified by staff as needing repairs.

A review of Preventative Maintenance Checklists for the period of October 2014, through to January 2015, fails to identify areas listed above as needing repair and or replacement.

The home's policy, Preventative Maintenance (OP-MTC-2.1), directs that preventive maintenance shall be conducted monthly in accordance with the monthly preventative maintenance checklist; deficiencies shall be documented and a plan for corrective action developed that addresses any/all deficiencies.

Maintenance Manager indicated that he/she had just been hired by the home and he/she is gradually looking at what needs to be repaired or replaced, but there was no formal documentation as of February 20, 2015 of what repairs needed to be completed. Maintenance Manager indicated some awareness of above issues (ceiling and toilet issues), but did indicate not being aware of other items listed above.

The Administrator/Director of Care indicated there is currently no corrective action in place to address the above deficiencies.

(554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

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. 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 will ensure that the resident staff communication and response system is available in every area accessible by residents, including:
- Activity room across from the Dining room
- Dining room
- Hairdressing room
- Physio Therapy room
- Lounges located at the end of Norwood and Asphodel Hallways

Grounds / Motifs :

1. The following resident areas were observed to have neither a call bell nor any other form of resident-staff communication and response system:

- Activity(lounge) room
- Dining room(s)
- Hairdressing room
- Physio Therapy room
- Both lounge areas are presently equipped with "bankers bells screwed to the wall"

Life Enrichment Coordinator indicated that if a resident required assistance when in the activity room, resident would have to wait until staff approached the room or could verbally call for assistance.

Administrator indicated awareness of resident's not having access to a resident staff communication and response system in the above indicated areas; stating 'those rooms never had call bells'.
(554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

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 4th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

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