Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 16, 2014	2014_179103_0024	O-000844-14	Resident Quality Inspection

Licensee/Titulaire de permis

PROVIDENCE CARE CENTRE
340 Union Street, KINGSTON, ON, K7L-5A2

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

PROVIDENCE MANOR
275 SYDENHAM STREET, KINGSTON, ON, K7K-1G7

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

DARLENE MURPHY (103), AMANDA NIXON (148), JESSICA LAPENSEE (133), JESSICA PATTISON (197), SUSAN DONNAN (531), WENDY PATTERSON (556)

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): September 3, 4, 5, 8, 9, 10, 11, 2014

Log #O-000742-14 was also included as a part of this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Resident Council President, Family Council President, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Occupational Health and Safety Coordinator, Manager Housekeeping, Laundry and Maintenance, Housekeeping staff, Manager of Dietary Department, Dietary staff, Director of Care and the Administrator.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed resident dining and reviewed the diet roster and therapeutic menus, reviewed medication administration including drug destruction practices and drug storage areas, observed resident care, the home's infection control practices including hand hygiene for staff and residents, reviewed resident health care records, and relevant home policies.

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
Pain
Personal Support Services
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 has failed to comply with O. Reg. 79/10, s. 17 (1) (e) in that the licensee has failed to ensure that the resident-staff communication and response system (the system) is available in every area accessible by residents.

On September 8th, 2014, Inspector #133 found that the system was not available in a wide variety of resident accessible areas throughout the home.

This widespread non-compliance presents potential risk to all residents of the home. As well, as it is not available, the system cannot be accessed or used by residents, staff, and visitors in the noted areas, as is required by O. Reg. 79/10, s. 17(1)(a). It is important that staff and visitors have the ability to make a call for assistance to nursing staff, with the system, when they are in an area with a resident.

The system was not available in the following resident accessible areas:

1st floor: Activity room (a.k.a pool table room), #1-1040, and both wheelchair accessible washrooms within the activity room, Auditorium (#1-1042), Wheelchair accessible washroom # 1-1064, Wheelchair accessible washroom #1-1065.

It is noted that there is an emergency phone in the Auditorium. This phone connects to the reception desk during coverage hours (8am-6pm), and then directly to a

security team out of Kingston General Hospital from 6pm-8pm. This does not meet the requirements for the resident-staff communication and response system.

2nd floor: Cafeteria, McKinley Room (resident lounge and activity space), Wellness centre (a physiotherapy exercise room), Archangel Arms (the resident pub),

5th floor – Sydenham dining room, Room #1-5023 (Montessori room), TV lounge across from Montreal nurses' station, Montreal dining room, Room #1-5084 (resident lounge), Room #1-5134 (welcome room, a resident lounge space),

3rd floor – Room #1-3084 (resident lounge), TV lounge across from Montreal nurses' station, Montreal dining room, Room #1-3023 (resident lounge), Sydenham dining room, Room #1-3135 (welcome room, a resident lounge space).

Inspector #133 met Resident #2 in room #1-3084 at 5:42 on September 8th, 2014. The system is not available in this room. Resident #2 told the Inspector that this was a room for prayer. Another unidentified resident came into the room, and they explained to the inspector that they intended to pray together. Resident #2 then indicated that due to some discomfort, the resident was planning to go to bed before saying prayers. The Inspector asked Resident #2's companion if they wanted a nurse to be notified. Resident #2's companion pointed out there was no "bell" in the room, and directed the Inspector to go into Resident #2's bedroom, and ring their bell, so that nursing staff will know to come and look for them. The Inspector went and informed nursing staff that Resident #2 was in need of assistance in room #1-3084.

It is to be noted that the Inspector did not observe all areas of the home. The Inspector did not observe any areas on the 4th floor. [s. 17. (1) (e)]

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).

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1. i. in that the licensee has failed to ensure that resident accessible doors leading to stairways, throughout the 1st floor, are kept closed and locked.

The widespread non-compliance described below presents a potential risk to residents, particularly to those who travel independently down to the home's 1st floor.

On September 8th, 2014, Inspector #133 went down to the home's first floor via the elevator in the main entrance area. It is noted that both the Montreal and Sydenham elevators go down to the 1st floor. It is noted that resident access to the elevators is restricted on the 5th floor care units. The Inspector spoke with staff in the attendant care outreach program office. Staff #S107 confirmed that residents do come down to the 1st floor and it's not unusual that staff reorient residents to the direction they are to go in in order to access resident areas, such as the auditorium. Staff #S107 said "they (residents) can get turned around, it's like a maze down here". This notion was reiterated by a member of the activity department, #S108, on August 9th, 2014. While discussing resident activities held in the Auditorium, and how residents get down to the 1st floor, staff #S108 indicated that "it can be like a maze down here for the residents, especially if they come down the Sydenham elevators".

In addition to attending activities within the Auditorium, residents may also go to the 1st floor in order to access the secured garden space, the Haughian Garden; to meet up with groups for bus outings; and to view the lost and found cart near the laundry services areas, which is also in the area of the Haughian Garden. On September 8th, 2014, Inspector #133 met resident #41 on the 1st floor, in the area of Locker Room A, which is to the right and down the hallway from the Sydenham elevators. The resident asked the inspector where they should go to find the bus group. A few minutes later, a recreation staff member, #S109 came along and explained to the Inspector that the bus pick up area was around the corner and down the hall past all of the kitchen service areas, at the ambulance services doors. The staff person explained that Resident #41 had come down earlier than needed as the group wasn't to meet for another 10 minutes. Staff #S109 and Resident #41 went together to the bus area.

Throughout the 1st floor, the Inspector noted seven resident accessible doors leading to stairways that are not equipped with a lock (stairwell #1 - #7). As well, these doors are not equipped with a door access control system, nor are they alarmed, as is required by O. Reg. 79/10, s. 9 (1) 1. ii. and iii.

It is noted that within each of the seven stairways, on level 1, there is a locked exit door leading to the outside of the home. Because the preceding doors were not secured at the time of the inspection, these exit doors are seen as resident accessible

doors that lead to the outside of the home, to which O. Reg. 79/10, s. 9 (1) 1. iii. applies, related to alarms. Stairway 3 is a noted exception. There is no alarm in place on the exit doors within stairway 1,2,4,5 and 7, which are only released in the event of a fire alarm. It was thought there was a form of alarm on the exit door within stairway #6, which is in the immediate are of the Sydenham elevator. On September 10th, 2014, the Manager of Housekeeping, Laundry and Maintenance Services and Inspector #133 determined that while there was a functional alarm at the door in the past, it was not functional at the time of the inspection.

There is no notification to staff if any of the exit doors that lead to the outside of the home, within the unsecured resident accessible stairways, throughout the 1st level, fail to close securely after being accessed. This further elevates risk to residents related to the unlocked stairway doors. [s. 9. (1)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1. iii. in that the licensee has failed to ensure that resident accessible doors leading to stairways, and resident accessible doors leading to the outside of the home, are alarmed as is prescribed.

None of the home's resident accessible doors that lead to stairways, or that lead to the outside of the home, including the front door, are alarmed as is required. On some doors, within the care units (levels 3-5), there is an alarm that self-cancels and is not connected as prescribed. These alarms are not compliant.

The widespread non-compliance described below presents potential risk to all residents of the home, as there is no notification to staff if such doors, including the front door, do not close securely after they have been accessed.

On September 8th, 2014, Inspector #133 went down to the home's first floor via the elevator in the main entrance area. It is noted that both the Montreal and Sydenham elevators go down to the 1st floor. It is noted that resident access to the elevators is restricted on the 5th floor care units. The Inspector spoke with staff in the attendant care outreach program office. Staff # S107 confirmed that residents do come down to the 1st floor and its not unusual that staff reorient residents to the direction they are to go in in order to access resident areas, such as the auditorium. Staff # S107 said "they (residents) can get turned around, it's like a maze down here". This notion was reiterated by a member of the activity department, #S108, on August 9th, 2014. While discussing resident activities held in the Auditorium, and how residents get down to

the 1st floor, staff #S108 indicated that "it can be like a maze down here for the residents, especially if they come down the Sydenham elevators".

In addition to attending activities within the Auditorium, residents may also go to the 1st floor in order to access the secured garden space, the Haughian Garden; to meet up with groups for bus outings; and to view the lost and found cart near the laundry services areas, which is also in the area of the Haughian Garden. On September 8th, 2014, Inspector #133 met resident #41 on the 1st floor, in the area of Locker Room A, which is to the right and down the hallway from the Sydenham elevators. The resident asked the inspector where they should go to find the bus group. A few minutes later, a recreation staff member, #S109 came along and explained to the Inspector that the bus pick up area was around the corner and down the hall past all of the kitchen service areas, at the ambulance services doors. The staff person explained that Resident #41 had come down earlier than needed as the group wasn't to meet for another 10 minutes. Staff #S109 and Resident #41 went together to the bus area.

Throughout the 1st floor, Inspector #133 noted seven resident accessible doors leading to stairways that are not alarmed (stairwell #1 - #7). As well, these doors are not equipped with a door access control system, nor are they locked, as is required by O. Reg. 79/10, s. 9 (1) 1. i. and ii. Also on the 1st floor, Inspector #133 noted one resident accessible door that leads to the outside of the home, exit door 2A (#1-1069A), that is locked but not alarmed. This door can only be released by a fire alarm.

It is noted that within each of the seven stairways, on level 1, there is a locked exit door leading to the outside of the home. Because the preceding doors were not secured at the time of the inspection, these exit doors are seen as resident accessible doors that lead to the outside of the home, to which O. Reg. 79/10, s. 9 (1) 1. iii. applies, related to alarms. Stairway 3 is a noted exception. There is no alarm in place on the exit doors within stairway 1,2,4,5 and 7, which are only released in the event of a fire alarm. It was thought there was a form of alarm on the exit door within stairway #6, which is in the immediate are of the Sydenham elevator. On September 10th, 2014, the Manager of Housekeeping, Laundry and Maintenance Services (the Manager) and Inspector #133 determined that while there was a functional alarm at the door in the past, it was not functional at the time of the inspection. There is no notification to staff if any of the exit doors that lead to the outside of the home, within the unsecured resident accessible stairways, throughout the 1st level, fail to close securely after being accessed. This further elevates risk to residents related to the

unalarmed stairway doors.

Inspector #133 and the Manager first met to discuss door security on August 9th, 2014. The Manager explained that some locked doors on care units that lead to stairways are equipped with an audible alarm and that the alarm cancels itself when the door closes. This is not as prescribed; door alarms are to be manually reset by a person, at the door. As well, it was confirmed that for doors that are equipped with an audible door alarm, the alarm is not connected to the resident-staff communication and response system OR to an audio visual enunciator at the closest nurses' station, as is prescribed.

On August 9th and 10th, 2014, the Inspector tested several doors and determined there was no audible alarm on the following doors (in addition to the stairway doors already noted throughout the 1st floor): front door, level 2 and 3 of stairway #3, level 2 and 3 and 4 of stairway #6, level 2 and 3 and 4 of stairway #2, level 2 of stairway #7.

None of the home's resident accessible doors that lead to stairways, or that lead to the outside of the home, including the front door, are alarmed as is required. On some doors, there is an alarm that self-cancels and is not connected as prescribed. The alarms that are in place are not compliant. [s. 9. (1)]

3. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 2 in that the licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and to ensure that those doors are kept closed and locked when they are not being supervised by staff.

The widespread non-compliance observed and described below presents a potential risk to all residents of the home.

i) The following resident accessible doors leading to non-residential areas, on the 1st floor, were noted to be non-compliant at the time of observation, on September 8th, 2014, between 12:30 pm and 2pm. It has been established that the 1st floor is resident accessible, and that residents do go to the 1st floor in order to access the Auditorium, the Haughian garden, the lost and found, and to meet up with groups for bus outings. The resident-staff communication and response system was not available in any of the noted areas on the 1st floor, as is required in all areas that residents have access to. Staff were not present and supervising the noted areas at the time of observation.

Locker room C (1-1008) – The door was not equipped with a functional lock. The room contained staff lockers.

Locker room B (1-1007) – While equipped with a lock, the lock was not engaged so as to prevent unsupervised access to the area by residents. The room contained staff lockers.

Locker room D (1-1012) – The door was not equipped with a lock. The room contained lockers, and a bathroom with a shower.

Locker room A (1-1017 and 1-1019(1)) – The two doors leading into this locker room are not equipped with locks. The large room contained lockers and 2 bathrooms, each with a shower.

Mechanical Room (1-1023) – The door was equipped with a lock, and it was engaged, but the door was not fully closed and therefore the room was not secured to restrict unsupervised access by residents. This room contained compressors, emergency power panels, and boxes of maintenance related items such as door knobs and brackets. While the inspector was observing the room, the home's Manager of Housekeeping, Maintenance and Laundry Services came along, and confirmed the expectation that this door should be fully closed and locked when not supervised.

Staff washroom (1-1026) – The door was not equipped with a lock. The inspector found the door wide open, and the light on.

Laundry room (1-1070) – The door was equipped with a lock, it was engaged, but the door was not fully closed and therefore the room was not secured to restrict unsupervised access by residents. This room contained washers and dryers, other related laundry equipment, buckets of laundry chemicals, a 4 Litre jugs of EcoLab Ultra San warewashing sanitizer and destainer on top of the buckets, and 3 more jugs of this product in a box next to the buckets. While the Inspector was in the room, laundry staff #S140 came into the room and confirmed that this door is supposed to be kept fully closed and locked when the area is not attended.

Soiled laundry room (1-1068) – The door was equipped with a lock, but the door was not closed or locked in order to prevent unsupervised access to the area by residents. The room contained laundry carts.

Housekeeping area (2-100) – The doors leading to this non-residential area are not equipped with a lock. The inspector found the following within the area:

a) Door #2-107 was open, this door leads to an area which contained a storage room, mainly for decorations (#2-109). Door #2-107 was not equipped with a lock that would prevent unauthorized access. Also in this area was a door that leads to a secured outdoor space (#2-110), which was not equipped with a lock.

b) Door #2-106 was open. This door leads to the housekeeping supervisor room. A sign on the door reads " this door must remain closed and locked. Contact Housekeeping Supervisor for admittance". This room contained stocked housekeeping carts and a variety of housekeeping equipment, supplies and cleaning products. Door #2-106A within this area was open, and this lead to a room that contained a large variety of cleaning products including polishes, cleansers and disinfectants.

At 2:04pm, while still in the housekeeping supervisor room, the Inspector contacted the ESM and reported these observations. The ESM arrived to the area promptly and stated that door #2-107 is to be closed and the thumb slide bolt on the door engaged when the area is not supervised. As well, door #2-106 is to be closed and locked without exception when the area is not supervised.

The inspector returned to this area at 6:41pm and again found that door #2-106, leading to the housekeeping supervisor room, was not closed and locked. There were no staff present in the area at the time of observation. The door leading to the main cleaning product storage room, #2-106A, was closed and locked at this time.

On September 9th, 2014, the Manager of Housekeeping, Laundry and Maintenance (the Manager) informed the inspector that the door leading into the housekeeping area, #2-100, was going to be locked. The Manager indicated that the work had started, and this was observed by the inspector.

ii) The following resident accessible doors leading to non-residential areas, on the 3rd, 4th and 5th floor care units, were noted to be non-compliant at the time of observation. The resident-staff communication and response system was not available in any of the noted areas, as is required in all areas that residents have access to. Staff were not present and supervising the noted areas at the time of

observation.

On September 8th, at approximately 3:38pm, Inspector #133 observed that door #1-1512A, leading into the dishwashing, food preparation and food storage area within the Sydenham dining room, was not fully closed and locked. The door was equipped with a lock. It was noted that within the room, there was a coffee maker that included a red spigot that dispensed hot water that that was steaming when emptied into a cup by the Inspector. As well, there was a spray bottle of Oasis 146 Multi Quat Sanitizer at the single dish sink. A Personal Support Worker (PSW) , Staff #141, came into the dining room while the Inspector was observing the back service area. The PSW explained that while the door is supposed to be kept closed and locked when not supervised, it is not always kept that way because they (PSWs) regularly need access to the items within, and only dietary staff and registered nursing staff have a key.

Inspector #133 returned to the Sydenham 5 dining room at 6:11pm on September 8th, 2014, and again found that door #1-1512A was not closed and locked. There were two residents in the dining room. There were no staff supervising the area. Inspector #133 returned to the Sydenham dining room at 2:21pm on September 9th, and again found that door #1-1512A was not locked. There were no staff supervising the area. On September 10th, 2014, at 3:36, the inspector again observed that this door was not locked. The inspector found a thermometer in the server and measured the temperature coming out of the red spigot on the coffee maker at 150F/65C. Residents are not to have access to water that is above 49C, due to risk of scalding. There were no staff supervising the area.

On September 8th, 2014, at 5:15, Inspector #133 observed that the door leading into linen room #1-3082 was open, and no staff were in the area supervising the door. The room contained shelving carts, on which there was resident care products such as briefs, gloves, cavi disinfectant wipes, and clean linens. The door was equipped with a lock, but it was not kept closed and locked in order to restrict unsupervised access to the area by residents.

On September 8th, 2014, at approximately 9:30am, Inspector # 197 observed a clean utility room door propped open. This was observed on the 5th floor, within the Sydenham unit. The room was noted to contain briefs, clean linens and resident care products such as disposable razors, and mouthwash. There were no staff in the area supervising the door at the time of observation. The door was equipped with a lock, but it was not kept closed and locked in order to restrict unsupervised access to the

area by residents.

On September 3rd, 2014, at approximately 10 am, Inspector #531 observed a clean utility room door that was not closed and locked, on the Montreal 4 unit. The door was noted to be equipped with a lock. Within the same time period on that day, Inspector #531 also observed that the door to a housekeeping room that contains an eye wash station on Montreal 4 was unlocked. It was noted that within the room, there was a cabinet, with a key in the door, that held cleaning supplies such as a disinfectant cleaner, a window cleaner, odour control pellets, and bottles of purell. The door was equipped with a lock, but it was not kept closed and locked in order to restrict unsupervised access to the area by residents.

On September 8th, 2014, at 9:30am, Inspector #531 observed the clean utility room door propped open on the Sydenham 4 unit. Within the room, inspector #531 observed supplies of mouthwash, body lotions, body wash, razors and roll on deodorant. The door was equipped with a lock, but it was not kept closed and locked in order to restrict unsupervised access to the area by residents.

On September 11, 2014, at 10:22am, Inspector #133 observed a clean utility room on Sydenham 4 wide open (#1-4005). The room contained briefs, linens, personal care products, and gloves. The door was equipped with a lock, but it was not kept closed and locked in order to restrict unsupervised access to the area by residents.

On September 11, 2014, at 10:26am, Inspector #133 observed that the Laundromat within the Montreal 4 unit, #1-4024, was not
locked. The door is not equipped with a lock that can prevent unauthorized entry. There is a small slide latch on the top of the door. The room contains a washing machine dedicated to laundering slings, and a dryer.

On September 11, 2014, at 10:30am, Inspector #133 observed an empty room , #1-4033, within the Montreal 4 Unit. Staff in the area informed this room is for storing the vacuum and dust mops. The door is not equipped with a lock that can prevent unauthorized entry. There is a small slide latch on the top of the door.

On September 11, 2014, at 10:40am, Inspector #133 observed Housekeeping Room #1-4094, within Montreal 4, was not locked. The room contained a floor buffer and a mop bucket in a sink. The door was equipped with a lock, but it was not kept closed and locked in order to restrict unsupervised access to the area by residents. It was

noted that the door would not close under its own weight. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 002, 003, 004 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. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On September 10th, 2014, Inspector #133 observed the Sydenham 3 dining rooms. Each dining room can be said to have three distinct sections. The section to the left of the server will be referred to as section C, mid areas as section B, and area to the left of the server as section A. In general, lower walls and heat registers were noted to be heavily soiled with dried food matter in continuous areas throughout each of the three dining rooms. Curtains and blinds in section A and B of Sydenham 5 were noted to be heavily stained and soiled with dried food matter. Dining Room chairs were noted to be soiled with dried food matter, most typically throughout the frame of the chair, and on the seat area or inner backrest on some chairs, for example: Sydenham 5 – chair closest to steam table area in section B, chair at table 5, in section C; Sydenham 3 – seven chairs within section A, two chairs at table 8 in section C, chairs at tables 5 and 6 in section B; Sydenham 4 – chairs in section A, chairs at tables 6 and 8 in section B, and chairs at tables 4 and 5 in section C. The base of tables was noted to be soiled with dried food matter in areas in Sydenham 4 dining room, for example: tables 1,5,6,7,8 and 2 of 4 tables within section A.

Over the course of Inspector #133's active inspection period at the home, September 8th-11th, 2014, a trend was noted whereby ceiling tiles adjacent to air vents were dirty with accumulated dust. The following are some examples of where this was observed: Montreal 5 dining room; outside of Sydenham 5 dining room, in front of nurses' station; in hallway, outside of bedroom #346; in hallway, outside of bedroom 425 and 426; hallway at Montreal 4 nurses' station; hallway outside of bedroom 446 and 454.

On September 11th, 2014, at approximately 10:35am, Inspector #133 went into the resident bathroom at the Montreal 4 nurses' station. Lower walls around the toilet and in front of the toilet were dirty with dried brown spots and dried dark coloured matter.

Inspector's observed additional examples as follows:

-Montreal 4- the floral high wing back chair located in the resident common area has dirty/scuffed legs (531),
- a large number of resident storage areas in the bathroom area (examples-Residents #8, #14, #39 and #11) are dirty with a visible layer of debris and spills (103),
-the sink in the whirlpool across from Room #309 is rusted and the inside of the storage drawer has visible debris (103),
- the whirlpool across from Room #332 was observed to have loose plaster lying on the floor on the wall on the right as you enter the room; the wall above this area has a large area of disrepair and a hole (103),
-the shower room located across from Room #360 has a wall mounted fan with a thick layer of visible dirt on it; the fan was on when the inspector entered the room and small bits of dust were blowing from the fan; additionally, the shower chair has yellow staining evident on the chair seat which is made of a grey foam-like material as well as on the safety belt(103)
-two wall mounted fans, located on Sydenham 5 hall, have a build-up of dirt (103),
- Resident #24's bathroom was observed to have towels, continence products and an unidentified foamy material on the floor (197),
-Resident #14's bathroom has a buildup of dirt at the base of the toilet at the floor edge (103), and
-there is a visible layer of dust on Montreal 3, door hinges of the fire doors located to the right of the nursing desk (103). [s. 15. (2) (a)]

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

repair.

On September 10th, 2014, Inspector #133 observed the 3 Sydenham dining rooms. Each dining room can be said to have 3 distinct sections. The section to the right of the servery (when facing it) will be referred to as section C, mid areas as section B, and area to the left of the servery as section A. In general, lower walls throughout sections A and B were noted to be in very poor repair. Areas throughout these sections were extensively scuffed and deeply gouged. At corners, such as on the post across from the windows in section A, and within areas between sections A and B, paint and drywall have been broken away, exposing the metal strapping beneath. This disrepair was also noted in the C sections, yet not to the degree and extent of what was seen in sections A and B.

Over the course of Inspector #133's active inspection period at the home, September 8th-11th, 2014, many heavily stained ceiling tiles were observed, throughout all areas of the home.

In the following areas, one or more ceiling tiles were notably stained, typically light and/or dark brown in colour, in a large section of the tile or in multiple sections within a tile: McKinley room, closer to the servery area, above a bulkhead; Montreal 2 elevator area; Sydenham 5 dining room, within the seating area to the left of the servery, next to one of the vents; Montreal 5 Dining Room, above the speaker; in hallway outside of room #1-5085; in hallway, above fan, outside of bedrooms #576 and #575; Tub room #1-3037, throughout the room and above toilet, where tile had sagged and cracked and was very heavily stained; Tub room #1-3018, throughout the room; Tub room closest to bedroom #309; Shower room #1-3087; 1st floor – locker room A; Hallway at bedroom 441; Montreal 4 dining room, in front of server; Montreal 4 resident washroom (#1-4059), above toilet; Sydenham 4 resident washroom #1-4004

In the following areas, stained ceiling tiles were also noted to have concentrated black centers or definitive black areas within the stained section, which was suggestive of mold growth: McKinley room, in the area of the piano and in the area of the fireplace; Sydenham 5 dining room above the hand sink and in the area of table 3 and 4; Sydenham 3 Tub Room #1-3018; in hallway outside of bedroom #547; Tub room #1-3018; 1st floor – hallway at room #1-1035, #1-1039, Locker room B.

On September 11th, 2014, in the area of housekeeping room #1-4095, in the Montreal 4 unit, there was a large ceiling tile in pieces on the floor. The pieces of tile were very

heavily stained and warped. There was a small white bucket in the area. There was nothing in the bucket.

Montreal 5 dining room – continuous area along bulkhead at windows that face Bay Street was stained, paint had chipped and peeled away within the affected area;

Tub Room #1-3037 – lower wall extensively damaged (deeply gouged, drywall down to metal strapping beneath);

Tub Room #1-3018 – lower wall extensively damaged (deeply gouged, drywall down to metal strapping); 1st floor – lower walls from the Sydenham elevator area down hallway around the Montreal elevator area were extensively damaged (areas are very deeply gouged, corners are down to metal strapping beneath drywall);

On September 9, 2014, Resident #41 showed Inspector #133 damage within their bedroom. The resident pointed out floor gouges, in front of their dresser and closet and bedside table. The resident told the inspector that these gouges had been in the room when they moved in, and that they had been told that the floor would be repaired. The resident said they were embarrassed about the gouges, and was always sure to tell visitors that they were not made by them. The resident pointed out that they have put a mat over the gouges at the bedside table in order to hide them, and that they would like to get some white paint so they could fill in the gouges to obscure them from view. Resident #41 pointed out to the inspector a large area on the ceiling in their bed area that had leaked, resulting in peeling paint and plaster. The resident said he/she was told the ceiling would be repaired when the area dried up, and said "its been like this for about a month and a half, and it must be dry by now". The resident pointed out another damaged area, the ceiling above the doorway. The area is stained and peeled. Resident #41 explained that a month or two ago, there was water leaking down through the light fixture and around the light fixture (upon entry to the room). Resident #41 said this caused them great alarm, and the light switch has since been taped in the off position in an effort to ensure it is not activated. Resident #41 said they were told that a pipe had burst within the ceiling space in the area of the fixture.

Resident #41 said to the Inspector "They have a lot of catching up to do in this building, I can see that everywhere I go".

Sydenham 5 – pillar in front of nurses' station were deeply gouged throughout lower

section with a hole in it.

Tub room on Montreal 4 care unit (#1-4036) – lower wall next to tub in very poor repair, areas deeply gouged and scuffed, with holes, and area at the sink damaged to expose metal strapping on corners.

Resident bathroom on Montreal 4 care unit (#1-4059) – walls extensively damaged, deeply gouged next to toilet and damaged to expose metal strapping at corners in two areas.

Inspectors observed additional examples as follows:

-Resident #39's bedroom has large areas of scuffs noted on left wall as entering room, there are numerous gouges in floor of bedroom at foot of bed and below window and window side of bed. The shared bathroom has rust noted around edges of sink, the finish on drain is missing and there is rust noted at the base of the faucet on the sink (103)
-Resident #14's bathroom sink has rust noted around the edge of the sink at the countertop, there is a buildup of dirt at the base of the toilet at the floor edge and scarring of paint at the bottom edges of door frames going into bathroom as well as on the base of the bathroom door. The light fixture as you enter the bedroom is missing a light cover (103),
-Resident #22's sink in the bathroom is rusted and missing finish (103),
- Resident #19's sink is rusted and missing finish (103),
-Resident #33's sink in the bathroom is rusted and missing finish (103),
-Resident #26's sink in the bathroom is missing finish (103),
-Resident #2's bathroom sink is rusty (103),
-the whirlpool located across from Room #360 has a yellow discolouration on the floor by tub and at the base of the toilet. There is a build up of debris at the tub edge and the rubber sealing on the tub is pulled away from the tub. The tub surface is scarred at the corner, the sink is rusted and the floor rad is missing paint. There is yellow staining on ceiling tile above toilet and a large open hole is present under the sink exposing the pipes for the tub (103),
-the shower room located across from Room #309- the sink is rusted and missing finish, flooring going into shower area is lifting/missing, there are large areas of missing/gouged paint on walls/doors, the shower chair back made of a webbing material is discoloured with a yellow/brown staining (103),
-the whirlpool located across from Room #332 has a hole and a large area of

missing/gouged paint on the wall on the right as you enter the room by tub, the sink is rusty and missing finish, the counter top is missing finish and there are areas on the wall missing plaster down to metal strapping. The storage dresser beside the tub has finish missing and the ceiling has yellowed tiles/holes from what appears to be water damage (103),
- Montreal 4 fireplace/tv room-the pillars are scuffed, the walls have drywall damage and chipped paint (531),
-Montreal 4-multiple drywall repair areas patched but unpainted by the elevator (531),
-Montreal 4-floral high wing back chair located in resident common area has scuffed legs and chipped/worn wooden arms (531),
-Resident #40's bedroom floor is scarred with a large area of black scuffs, the bedside table is chipped/worn and the base wood is peeling (531),
- Resident #24 has no toilet in the shared bathroom; only a commode (197),
-Resident #3's bathroom has black scuffs over the lower areas of the walls with black scuff marks (531),
- Resident #21's bedroom has multiple black scuff marks on the floor, the drywall is missing on corners, paint and corkboard is missing along the bottom of the clothes closet doors; the door frames including the bathroom entrance door is missing large areas of drywall. The electric outlet in the wall behind the chair by the bedside table has two plugs plugged in, but there is no electrical cover. This resident's shared bathroom has a large hole in the drywall by the sink. Resident #21 told this inspector that he/she has asked for the areas to be repaired and painted a number of months ago, but feels they only do that when another resident moves into the room (531),
- Resident #10's bedroom has multiple long black scuff marks on the entrance way, washroom door, and along both walls; there is chipped/cracked paint on the doors and rubber seal top of the door is falling off (531),
-Resident #22's bedroom has large areas of scuffs on the wall at the foot of bed, the baseboard is pulled away from the wall and there are gouges on the floor by the night stand. There are areas of plaster missing on the corner going into the bathroom down to the metal strapping and also at closet and there is scuffing across the bathroom door (103),
- the small ante/common area located outside of the Montreal 3 dining area-there is a large area on the wall that is heavily scuffed with plaster chipped and paint missing (103),
- Resident #24's bedroom has heavy scarring on the bedroom and bathroom doors as well as walls around closet and bathroom doors. Large pieces of drywall/plaster missing (197),
-Resident #33's bathroom has missing paint on the bathroom doors and the frame of

the door (103),
-Resident #15's bedroom wall on the right side of the room is scuffed with black marks (531), and
-the Sydenham elevator has large areas of missing paint. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 71(1)(c) in that the home's menu cycle for resident's on a pureed diet does not always include an alternate choice of entree and vegetable at lunch and dinner.

On September 3, 2014, Inspector #148 observed the lunch meal service in the 4th floor Sydenham dining room. Meal items prepared and available for the puree texture modification included meat balls and pasta with green peas and bread as the first choice. In addition, two Trepuree meals were available as second choice each containing chicken and an unknown starch, one with peas and the second with carrots. The two Trepurees were provided to two residents at the beginning of the meal service. The diet roster, used by the food service worker (FSW) during the meal service, indicates there are four residents requiring puree texture modification.

On September 3, 2014, Inspector #197 observed the lunch meal on the 5th floor in the Sydenham dining room. Personal Support Workers were observed ordering meals for residents requiring a pureed texture diet and noted that at this particular time in the meal service there was only one option available.

During an interview with Dietary Aid #S133 she stated that there were two options on the pureed menu today, however, other residents had ordered the second option and it was now gone. The remainder of the residents in the dining room on a pureed diet did not receive a choice for their entree.

On September 4, 2014, Inspector #148 observed the lunch meal service in the 4th floor Sydenham dining room. Meal items prepared and available for the puree texture modification included tuna sandwich with tomato salad as the first choice. In addition, two Trepuree meals were available as second choice each containing beef, potato and carrots. Choice was not available for Residents #10 and #52 after the two Trepuree meals were given out.

On September 9, 2014, Inspector #197 observed the lunch meal on the 5th floor in the Sydenham dining room. Meal items prepared and available for the puree texture menu included egg salad sandwich with carrot salad as the first choice and a roast beef Trepuree meal as the second choice. The diet roster indicated that eight residents in the dining room required a pureed texture meal; one who requires triple portions. At the beginning of the meal service it was noted by the inspector that there were only five servings of the second choice for the pureed menu.

Personal Support Worker #S113 was observed asking Dietary Aid #S134 for a hot pureed meal for Resident #53. Dietary Aid #S134 indicated that they were out of hot entrees for residents requiring a pureed texture meal, leaving only one choice for the resident's entree and vegetable.

The diet roster for the unit states for Resident #54 to "please give 3 Trepuree meals when first choice is cold". Since the first choice was cold, this resident should have been given 3 Trepuree meals.

Dietary Aid #S134 stated that Resident #54 only received one Trepuree meal because four other residents also ordered Trepuree meals as their choice. Since there were only five Trepuree meals available, Resident #54 got two portions of the cold option instead even though the diet roster clearly indicates that he should be getting three

Trepuree meals.

Upon review of the home's therapeutic pureed texture menu for weeks 1 and 2, it was noted that for twenty six out of twenty eight lunch/dinner meals, a Trepuree meal was offered as the second choice. Since a Trepuree meal includes meat, vegetable and starch all together in one dish, residents who order the first pureed option do not have a choice of vegetable at the lunch and dinner meals. In addition, the home's planned therapeutic menu for the pureed texture does not indicate what the choice of vegetable will be for the second choice. [s. 71. (1) (c)]

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 residents that require a texture modified diet have two choices available at lunch and dinner meals, to be implemented voluntarily.

WN #5: 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. (5) The licensee shall ensure,
(a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective; O. Reg. 79/10, s. 136 (5).
(b) that any changes identified in the audit are implemented; and O. Reg. 79/10, s. 136 (5).
(c) that a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 136 (5).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 136 (3) whereby a non-controlled substance that is to be destroyed is not done by a team acting together.

On September 9, 2014, during an interview with S#115 and S#120, both confirmed that non-controlled drugs for destruction are placed in the plastic container and taken to the pharmacy room for disposal. Neither staff were aware of the need to destroy non-controlled drugs as a team acting together.

On September 10th, the Director of Care was interviewed and confirmed the non-controlled medications for destruction are not destroyed by a team acting together.

Review of the homes "Inventory Control - Drug Disposal" Disposal of Discontinued/expired Medications Page two #4 states: for other medications (non-narcotic), one member of the registered staff appointed by the Director of Care/Director of Nursing/ Resident Service Manager and one other staff member will act as a team to destroy the medications in the nursing homes, or facility authorized care giver in other facilities. They will render the discarded medications unusable and seal medications in the destruction containers provided by the biohazardous waste company that is selected by the pharmacy." [s. 136. (3) (b)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 136 (5)(a)(c) whereby the drug destruction and disposal system was not audited at least annually to verify that the licensee's procedures are being followed and are effective and a written record kept.

On September 10th, 2014 during an interview with the Director of Care, she confirmed that the drug destruction and disposal system is not audited annually to verify that the licensee's procedures are being followed and are effective. [s. 136. (5)]

3. The licensee has failed to comply with O. Reg. 79/10, s. 136 (6) whereby the non-controlled drugs are not denatured.

On September 10th, 2014, the Director of Care was interviewed and confirmed that non-controlled drugs are placed in plastic disposal containers on the home areas or in the yellow biohazardous waste bag for the contracted company to pick up and that the drugs are not denatured. [s. 136. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the drug destruction and disposal of non-controlled drugs are done as a team acting together and include an annual audit of the effectiveness, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 229 (4) whereby staff do not participate in the implementation of the infection control program as it pertains to the cleaning and sharing of personal care equipment.

During the course of the inspection, the following was observed:
-Resident #29's wheelchair was soiled with food like debris (197),
-Resident #39's shared bathroom was observed to have kidney basins heavily soiled with a whitish material and a soiled bedpan stored inside a washbasin on the open

shelf above the toilet (103),
-Resident #14's shared bathroom was observed to have a soiled kidney basin with whitish residue (103),
-The whirlpool bath located outside room 360 was observed to have a build up of debris at the edge of the tub and the rubber seal on the tub was dirty, and there were two unlabelled hairbrushes and a comb with hair evident in each (103),
-The shower room located outside of room 360 had three extensively used bars of soap, an unlabelled wooden handled brush with hair evident in the brush, two open and used deodorants and two used razors left on the shelf in the shower room (103),
-The whirlpool room located across from room #309 had an unwrapped toothbrush stored within a drawer in the room and the drawer was visibly soiled with debris; there were also unlabelled used hair brushes with hair evident and unlabelled deodorants (103),
-The whirlpool room on Montreal 5 was observed to have six unlabelled hair brushes with hair evident, 4 used razors and six open and used deodorants (197),
-The whirlpool room located across from room 332 contained three unlabelled and used deodorants, three unlabelled wash puffs and one used razor sitting on top of the stand beside the tub (103),
-numerous rooms throughout all three resident floors were observed to have towels and briefs stored on the open shelving units located behind the resident toilets.

Personal support worker (PSW) staff were interviewed and stated the open shelves above the toilets in the bathrooms are to be used for the storage of resident wash basins and bedpans. PSW#110 stated towels and briefs are not to be stored on the open shelving units behind the toilets as this would be considered cross contamination of clean and dirty items.

Cleaning of resident care equipment in the home is a part of the infection control program policy #2-07 Cleaning and Disinfection which states under "Purpose": appropriate decontamination of residents care equipment is essential in the prevention of infection.
Under, "Policy":
2.1 applies to all resident care equipment,
2.2 items will not be shared between residents without being cleaned between usage,
2.3 all shared items must be washed and disinfected,
2.4 bathtubs, tub chairs and shower chairs will be cleaned and disinfected by nursing staff in between usage and by housekeeping staff at the end of the day.

Procedure to follow to pick up, cleaning and decontamination of resident equipment: K-basins, bedpans, urinals etc.:
evening staff are required to pick up items and place in dirty utility room in preparation for night staff to do the cleaning.
Rotation schedule of 10 rooms per night.
-example Monday rooms 323-333
Items are returned by night staff and left on the railing for day staff to return to the resident room.

Several staff were interviewed (S#110, S#115, S#120, S#123, S#143, S#145 and S#144) and confirmed the process is in place but stated it may not always get done if night staff are busy. [s. 229. (4)]

2. The licensee has failed to comply with O. Reg 79/10 s. 229 (10) 1. whereby screening for tuberculosis is not completed within fourteen days of admission.

S#106, Coordinator for Occupational Health and Infection Control, was interviewed in regards to the home's screening method for tuberculosis (TB). She stated the local Public Health Unit has not finalized the proposed changes to the screening process and therefore, the home continues to utilize the two step mantoux testing for the TB screening of all residents admitted to the home.

The immunization status for the following residents were reviewed: Resident #43, #44, #45, #46, #47, #48, #49, #50.

Resident #43, #45, #46, #48, #49, and #50 were not screened for TB within fourteen days of admission. [s. 229. (10) 1.]

3. The licensee has failed to comply with O. Reg 79/10 s. 229 (10) 3 whereby residents are not offered immunizations against pneumoccocus, tetanus and diphtheria.

The immunization records for the following residents were reviewed: Resident #43, #44, #45, #46, #47, #48, #49, and #50. There was no documented evidence to support residents being offered immunizations against pneumoccocus, tetanus or diphtheria. Registered staff #103, #104 and #105 were interviewed and stated residents are not offered these immunizations but stated on occasion a resident may receive a tetanus shot for an injury sustained within the home.

S#106 was interviewed and was asked to review the same sample of residents to provide evidence of the residents being offered these immunizations. After reviewing the sample of residents, S#106 stated there is a lack of consistency in providing these immunizations to residents. [s. 229. (10) 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 to ensure staff participate in the implementation of the infection control program as it relates to: i)the cleaning and sharing of personal resident items, ii)the screening of tuberculosis within fourteen days of a resident admission and iii) the offering diphtheria, tetanus and pneumoccocus immunizations to residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 3 (1) 1. whereby the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was not promoted.

Throughout the inspection period, this inspector observed many shared resident bathrooms with briefs stored on the open shelves located above the resident toilet. This included shared bathrooms for Residents #8, #22, #33, #14, and #26. Resident #7's shared bathroom was observed to have a colostomy bag soaking in water and stored on the open shelving area. All shared bathrooms were observed to have storage areas with doors for the storage of resident personal items.

Personal support worker (PSW) staff were interviewed and stated the open shelves in

the bathrooms are used for the storage of resident wash basins and bedpans. PSW staff agreed briefs should be stored within the personal resident storage areas in the bathrooms out of view.

Throughout this inspection period, resident transfer status and brief logos (where applicable) were observed to be posted directly above the resident's head of the bed. The transfer logos are 8.5" x 11", placed within a lamination cover and both are taped to the overbed light and visible upon entering the resident room. The brief logos indicate the size of the resident brief to be applied on days/evenings and nights.

The Director of Care was interviewed and agreed resident briefs and brief logos should be posted in a discreet location and by failing to do so, does not support resident dignity. Additionally, the DOC agreed the transfer logos could be much smaller and yet still visible to staff to promote a more home-like environment for all residents.

On September 10, 2014 on or about 1135 hour, Resident #56 was observed to be seated on a walker outside the Sydenham 5 dining room and was actively conversing with a co-resident who was seated in a wheelchair. Resident #56 was approached by the registered staff member who proceeded to lift the resident's shirt, exposed the resident's abdominal area and an injection was given into the left side of the abdomen. In addition to the resident seated next to Resident #56, there were three additional residents seated in the immediate area as well as two registered staff at the desk and the medical director.

Discussion was held with the Administrator who agreed the administration of an injection in a common area would not promote a resident's dignity. [s. 3. (1) 1.]

2. The licensee has failed to comply with LTCHA, 2007, s. 3 (1) 11. iv whereby resident personal health information is not kept confidential.

The following observations were made during the inspection period:
-Resident #8's shared bathroom has a notice posted by staff on the wall related to the cleaning of the resident's colostomy bag,
-Resident #20 has a notice posted above the resident's bed instructing staff to apply "interdry in groins daily",
-Resident #26 has a frequent falling observation tool posted on the resident's closed bedroom door and visible to anyone from the hallway.

These postings fail to ensure resident personal health information is kept confidential as the notices can be viewed by a wide variety of people. [s. 3. (1) 11. iv.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 37. (1) whereby personal items were unlabelled.

-Resident #32's shared bathroom room was observed to have unlabelled dentures in an unlabelled denture cup beside the sink and unwrapped/unlabelled toothbrush in a drawer (197),
-Resident #11's bathroom was observed to have a unlabelled, used toothbrush on the counter sitting in a soiled k-basin (103),
-Resident #23's shared bathroom was observed to have an unlabelled hairbrush and toothbrush (197),
-Resident #39's shared bathroom was observed to have four unlabelled toothbrushes sitting in unlabelled cups on bathroom counter (103),
-Resident #13's shared bathroom was observed to have five unlabelled toothbrushes, a pair of nail clippers, roll on deodorant, a hairbrush, two combs, and two denture cups piled on top of each other (531),
-Resident #14's shared bathroom was observed to have an unlabelled toothbrush and brush sitting on the counter (103),
-Resident #35's shared bathroom was observed to have unlabelled toothbrush, used unlabelled manual and electric razor, and an unlabelled electric toothbrush and nasal clippers (531),
-Resident #6's shared bathroom was observed to have unlabelled creams, lotion, denture cups, toothbrushes and toothpaste (531),
-Resident #20's shared bathroom was observed an unlabelled toothbrush on the counter (103).

Personal support workers were interviewed (S#120, S#123, S#110, S#137, S#143, and S#145) as well as the Director of Care and all confirmed that the resident personal care items are to be labelled by the personal support staff. [s. 37. (1) (a)]

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73 (1) 10. in that proper techniques were not used to assist residents with eating.

On September 3, 2014, the lunch meal was observed on the 5th floor in the Sydenham dining room. Personal Support Worker #S113 was observed to assist Resident #55 with the entire meal while in a standing position.

Resident #55's care plan related to eating states the resident requires a pureed texture meal, thickened fluids and is totally dependent requiring complete feeding by one staff member. [s. 73. (1) 10.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 73 (2)(b) in that residents who required assistance with eating or drinking were served their meal before assistance was available.

The plan of care for Resident #10 and Resident #52 indicate that both residents require total feeding assistance from a staff member.

On September 3, 2014, Inspector #148 observed the provision of the lunch meal service to Resident #10 and Resident #52. Both residents were provided the Trepuree meal at 12:03pm. At the time each resident was provided their meal, no staff member was available to provide assistance. Resident #52 was provided feeding assistance at 12:09pm and Resident #10 was provided feeding assistance at 12:14pm.

The Dietary Aide #S139 indicated that both resident's prefer to receive their meals first as they are difficult to feed and require time to eat and safely swallow. The health care records for both residents were reviewed and this was not indicated in the plans of care.

Resident #10 and Resident #52, who both require assistance with eating, were served a meal prior to a staff member being available to provide the assistance required by the resident.

The plans of care for Residents #18 and #53 indicate that they both require total feeding assistance by one staff member.

On September 3, 2014, Inspector #197 observed the lunch meal on the 5th floor in the Sydenham dining room. At 1243 hours, Residents #18 and #53 were provided with their desserts. A staff member did not sit down to assist either resident with their dessert until 1250 hours. [s. 73. (2) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 87 (2)(d) in that the licensee has failed to address incidents of lingering offensive odour.

On September 8th, at approximately 5pm, Inspector #133 went into the shared bathroom of Resident #24. There was a strong lingering odour of urine in the bathroom. There was no toilet in this bathroom. The toilet had been broken and was going to be replaced. A commode was in place for the resident's use, in the area where the toilet used to be. There was no urine within the commode at the time of observation, but the commode appeared to be dirty with dried urine residue. The commode arm rest was dirty with dried brown matter, and there were a few small

areas of dried brown matter on the outer commode lid.

On September 9th, at 2:11pm, Inspector #133 returned to the shared bathroom of Resident #24 and there was a strong lingering odour of urine. There was urine in the commode. The inspector spoke with a Personal Support Worker, #S128, who confirmed that it is the responsibility of the nursing department to empty and clean the commode. Staff #S128 stated that they would empty it and clean it thoroughly before the end of shift, 3pm.

On September 9th, at approximately 4:15pm, Inspector #133 returned to the shared bathroom of Resident #24 and there was a lingering odour of urine. The commode had obviously been scrubbed clean as much as possible, yet was notably stained and appeared to be odourous. There was a brief in the garbage in the bathroom, next to the commode. There was also a brief in the garbage in the bedroom, with a pair of gloves that are used by nursing staff, on top of the brief in the garbage. It is not known if either brief was soiled.

On September 10th, at 10:49am, Inspector #133 returned to this shared bathroom and there was a strong lingering odour of urine and feces in the bathroom. There was urine and feces in the commode. There was a brief in the garbage in the bathroom, can next to the commode. It is not known if the brief was soiled.

On September 10th, at 12:43 pm, Inspector #133 returned to Resident #24's shared bathroom. There was a strong lingering odour of urine and feces in the bathroom. The urine and feces seen in the commode at 10:49am was still the commode. The brief in the garbage can in the bathroom, next to the commode, remained in place. As the Inspector was leaving the bedroom, nursing staff was observed bringing the resident back into their room following the lunch meal.

September 10th, at 1:45 pm, Inspector #133 returned to the shared bathroom of Resident #24 and there was a strong lingering odour of urine and feces in the bathroom. The urine and feces seen at 10:49am and 12:43pm remained in the commode, as did the brief in the garbage can, next to the commode.

On September 10th, at 3:15 pm, Inspector #133 returned to this same shared bathroom and there was a strong lingering odour of urine. The commode had a small amount of liquid in it, including fecal particulate. The garbage can in the bathroom had been moved under the sink but had not been emptied, the brief remained.

On September 10th, at 4:34 pm, Inspector #133 returned to Resident #24's shared bathroom. There was a strong lingering odour of urine in the bathroom. The commode had a very small amount of liquid in it, and the fecal particulate was no longer there. The Inspector noticed that there was a pair of gloves that are used by nursing staff, in the garbage can, on top of the brief that had been observed throughout the day.

The exact source of the lingering offensive odour could not be determined, however, lingering offensive odour was noted in the shared bathroom of Resident #24 over a three day period. [s. 87. (2) (d)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 134 (a) whereby the monitoring and effectiveness of an analgesic was not documented.

Resident #24 has a diagnosis of chronic pain. According to the RAP dated July 27/14, the resident states the pain never goes away. Resident #24 receives regular doses of a narcotic as well as an additional narcotic every two hours for breakthrough pain. On an identified date, the resident sustained a fall and subsequently reported additional back pain. The resident's August Medication Administration Record (MAR) was reviewed and during this month, eleven doses of the breakthrough medication was administered. The home documented the effectiveness of the breakthrough medication five out of the eleven times it was administered. The resident's plan of care was reviewed. The care plan related to pain stated:

Frequent moderate pain or discomfort (pain daily)*:
Resident has constant pain, receives medication as per directions on MARS
Position pillows when in bed for added comfort
Encourage resident to express when experiencing pain, so breakthrough medications can be given to help decrease pain level.
When resident refuses medications, remind resident the importance of taking them, so that the pain doesn't get out of control.

Staff were interviewed and agreed it would be important to reflect the effectiveness of the pain medications when the resident is accepting of the analgesics to maximize the effectiveness of pain control. [s. 134. (a)]

Issued on this 16th day of September, 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) :	DARLENE MURPHY (103), AMANDA NIXON (148), JESSICA LAPENSEE (133), JESSICA PATTISON (197), SUSAN DONNAN (531), WENDY PATTERSON (556)
Inspection No. / No de l'inspection :	2014_179103_0024
Log No. / Registre no:	O-000844-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 16, 2014
Licensee / Titulaire de permis :	PROVIDENCE CARE CENTRE 340 Union Street, KINGSTON, ON, K7L-5A2
LTC Home / Foyer de SLD :	PROVIDENCE MANOR 275 SYDENHAM STREET, KINGSTON, ON, K7K-1G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHELAGH NOWLAN

To PROVIDENCE CARE CENTRE, 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 :

In order to achieve compliance with O. Reg. 79/10, s. 17 (1) (e), the licensee will ensure the following:
a) that the resident-staff communication and response system (the system) is made available in every area accessible by residents.
It must be noted that the system is required in such areas for use by residents, staff and visitors, as per O. Reg. 79/10, s.17 (1)(e). The fact that residents may only be in a certain areas under the supervision of staff, such as in a physiotherapy room, does not negate the need for system availability.
Until such time that the licensee is in full compliance with O. Reg. 79/10, s. 17 (1) (e), formalized measures shall be taken to ensure resident safety in light of the lack system availability in common areas throughout the home (with the exception of tub and shower rooms).

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 17 (1) (e) in that the licensee has failed to ensure that the resident-staff communication and response system (the system) is available in every area accessible by residents.

On September 8th, 2014, Inspector #133 found that the system was not available in a wide variety of resident accessible areas throughout the home.

This widespread non-compliance presents potential risk to all residents of the home. As well, as it is not available, the system cannot be accessed or used by residents, staff, and visitors in the noted areas, as is required by O. Reg. 79/10, s. 17(1)(a). It is important that staff and visitors have the ability to make a call for assistance to nursing staff, with the system, when they are in an area with a resident.

The system was not available the following resident accessible areas:

1st floor: Activity room (a.k.a pool table room), #1-1040, and both wheelchair accessible washrooms within the activity room, Auditorium (#1-1042), Wheelchair accessible washroom # 1-1064, Wheelchair accessible washroom #1-1065.

It is noted that there is an emergency phone in the Auditorium. This phone connects to the reception desk during coverage hours (8am-6pm), and then directly to a security team out of Kingston General Hospital from 6pm-8pm. This does not meet the requirements for the resident staff communication and response system.

2nd floor: Cafeteria, McKinley Room (resident lounge and activity space), Wellnesss centre (a physiotherapy exercise room), Archangel Arms (the resident pub)

5th floor – Sydenham dining room, Room #1-5023 (Montessori room), TV lounge across from Montreal nurse station, Montreal dining room, Room #1-5084 (resident lounge), Room #1-5134 (welcome room, a resident lounge space),

3rd floor – Room #1-3084 (resident lounge), TV lounge across from Montreal nurse station, Montreal dining room, Room #1-3023 (resident lounge), Sydenham dining room, Room #1-3135 (welcome room, a resident lounge space).

Inspector #133 met resident #2 in room #1-3084 at 5:42 on September 8th, 2014. The system is not available in this room. Resident #2 told the Inspector

that this was a room for prayer. Another unidentified resident came into the room, and they explained to the inspector that they intended to pray together. Resident #2 then indicated that due to some discomfort in the neck area the resident was planning to go to bed before saying prayers. The Inspector asked Resident #2's companion if they wanted a nurse to be notified. Resident #2's companion pointed out there was no "bell" in the room, and directed the Inspector to go into Resident #2's bedroom, down the hallway, and ring their bell, so that nursing staff will know to come and look for them. The Inspector went and informed nursing staff that resident #2 was in need of assistance in room #1-3084.

It is to be noted that the Inspector did not observe all areas of the home. The Inspector did not observe any areas on the 4th floor.
(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 16, 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. 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 :

In order to achieve compliance with O. Reg. 79/10, s. 9 (1) 1. iii., the licensee will ensure the following:
a) that all resident accessible doors leading to stairways, and all resident accessible doors that lead to the outside of the home, are equipped with an audible door alarm, and
b) that the door alarms can only be cancelled at the point of activation, which is the door, and
c) that the door alarms be connected to the resident – staff communication and response system (the system), OR
d) that the door alarms be connected to an audio visual enunciator that is connected If the alarms are to the nurses' station nearest to the door and has a manual reset switch at each door.
It must be noted that door alarms cannot self-cancel. A person must have to go to the door to cancel the alarm.
Until such time that the licensee is in full compliance with O. Reg. 79/10, s. 9 (1) 1. iii, formalized measures shall be taken to ensure resident safety in light of the lack on alarm on all applicable doors, which results in an absence of notification to staff if such doors have failed to close securely after being accessed.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1. iii. in that the licensee has failed to ensure that resident accessible doors leading to stairways, and resident accessible doors leading to the outside of the home, are alarmed as is prescribed.

None of the home's resident accessible doors that lead to stairways, or that lead to the outside of the home, including the front door, are alarmed as is required. On some doors, within the care units (levels 3-5), there is an alarm that self-cancels and is not connected as prescribed. These alarms are not compliant.

The widespread non-compliance described below presents potential risk to all residents of the home, as there is no notification to staff if such doors, including the front door, do not close securely after they have been accessed.

On September 8th, 2014, Inspector #133 went down to the home's first floor via the elevator in the main entrance area. It is noted that both the Montreal and Sydenham elevators go down to the 1st floor. It is noted that resident access to the elevators is restricted on the 5th floor care units. The Inspector spoke with staff in the attendant care outreach program office. Staff # S107 confirmed that

residents do come down to the 1st floor and its not unusual that staff reorient residents to the direction they are to go in in order to access resident areas, such as the auditorium. Staff # S107 said "they (residents) can get turned around, it's like a maze down here". This notion was reiterated by a member of the activity department, #S108, on August 9th, 2014. While discussing resident activities held in the Auditorium, and how residents get down to the 1st floor, staff #S108 indicated that "it can be like a maze down here for the residents, especially if they come down the Sydenham elevators".

In addition to attending activities within the Auditorium, residents may also go to the 1st floor in order to access the secured garden space, the Haughian Garden; to meet up with groups for bus outings; and to view the lost and found cart near the laundry services areas, which is also in the area of the Haughian Garden. On September 8th, 2014, Inspector #133 met resident #41 on the 1st floor, in the area of Locker Room A, which is to the right and down the hallway from the Sydenham elevators. The resident asked the inspector where they should go to find the bus group. A few minutes later, a recreation staff member, #S109 came along and explained to the Inspector that the bus pick up area was around the corner and down the hall past all of the kitchen service areas, at the ambulance services doors. The staff person explained that Resident #41 had come down earlier than needed as the group wasn't to meet for another 10 minutes. Staff #S109 and Resident #41 went together to the bus area.

Throughout the 1st floor, Inspector #133 noted seven resident accessible doors leading to stairways that are not alarmed (stairwell #1 - #7). As well, these doors are not equipped with a door access control system, nor are they locked, as is required by O. Reg. 79/10, s. 9 (1) 1. i. and ii. Also on the 1st floor, Inspector #133 noted one resident accessible door that leads to the outside of the home, exit door 2A (#1-1069A), that is locked but not alarmed. This door can only be released by a fire alarm.

It is noted that within each of the seven stairways, on level 1, there is a locked exit door leading to the outside of the home. Because the preceding doors were not secured at the time of the inspection, these exit doors are seen as resident accessible doors that lead to the outside of the home, to which O. Reg. 79/10, s. 9 (1) 1. iii. applies, related to alarms. Stairway 3 is a noted exception. There is no alarm in place on the exit doors within stairway 1,2,4,5 and 7, which are only released in the event of a fire alarm. It was thought there was a form of alarm on the exit door within stairway #6, which is in the immediate are of the Sydenham

elevator. On September 10th, 2014, the Manager of Housekeeping, Laundry and Maintenance Services (the Manager) and Inspector #133 determined that while there was a functional alarm at the door in the past, it was not functional at the time of the inspection. There is no notification to staff if any of the exit doors that lead to the outside of the home, within the unsecured resident accessible stairways, throughout the 1st level, fail to close securely after being accessed. This further elevates risk to residents related to the unalarmed stairway doors.

Inspector #133 and the Manager first met to discuss door security on August 9th, 2014. The Manager explained that some locked doors on care units that lead to stairways are equipped with an audible alarm and that the alarm cancels itself when the door closes. This is not as prescribed; door alarms are to be manually reset by a person, at the door. As well, it was confirmed that for doors that are equipped with an audible door alarm, the alarm is not connected to the resident-staff communication and response system OR to an audio visual enunciator at the closest nurses' station, as is prescribed.

On August 9th and 10th, 2014, the Inspector tested several doors and determined there was no audible alarm on the following doors (in addition to the stairway doors already noted throughout the 1st floor): front door, level 2 and 3 of stairway #3, level 2 and 3 and 4 of stairway #6, level 2 and 3 and 4 of stairway #2, level 2 of stairway #7.

None of the home's resident accessible doors that lead to stairways, or that lead to the outside of the home, including the front door, are alarmed as is required. On some doors, there is an alarm that self-cancels and is not connected as prescribed. The alarms that are in place are not compliant.
(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 16, 2015

Order # / Ordre no : 003

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 :

In order to achieve compliance with O. Reg. 79/10, s. 9 (1) 2., the licensee will ensure the following:
a) That all resident accessible doors that lead to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and
b) That all resident accessible doors that lead to non-residential areas are kept closed and locked when they are not being supervised by staff.
As well, the licensee will conduct a full home audit, so that each and every resident accessible door that leads to a non-residential area is noted and targeted for follow up.
If the licensee chooses to designate some areas not typically understood to be a residential area as a residential area, such as a clean utility room, then the licensee must ensure that the resident-staff communication and response system is available in those areas, as is required by O. Reg. 79/10, s. 17 (1) (e). As well, the licensee would have to ensure there is no access to hazardous products in said areas, as per O. Reg. 79/10, s. 91, and that overall, there is nothing that presents a potential safety risk to residents, as per LTCHA, 2007, S.O. 2007, c. 8, s. 5. A non-residential area is one in which residents do not typically receive care and/or services.
Until such time that the licensee is in full compliance with O. Reg. 79/10, s. 9 (1) 2., formalized measures shall be taken to ensure resident safety with regards to their unrestricted access to non-residential areas.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 2 in that the licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and to ensure that those doors are kept closed and locked when they are not being supervised by staff.

The widespread non-compliance observed and described below presents a potential risk to all residents of the home.

i) The following resident accessible doors leading to non-residential areas, on the 1st floor, were noted to be non-compliant at the time of observation, on September 8th, 2014, between 12:30 pm and 2pm. It has been established that the 1st floor is resident accessible, and that residents do go to the 1st floor in order to access the Auditorium, the Haughian garden, the lost and found, and to meet up with groups for bus outings. The resident-staff communication and

response system was not available in any of the noted areas on the 1st floor, as is required in all areas that residents have access to. Staff were not present and supervising the noted areas at the time of observation.

Locker room C (1-1008) – The door was not equipped with a functional lock. The room contained staff lockers.

Locker room B (1-1007) – While equipped with a lock, the lock was not engaged so as to prevent unsupervised access to the area by residents. The room contained staff lockers.

Locker room D (1-1012) – The door was not equipped with a lock. The room contained lockers, and a bathroom with a shower.

Locker room A (1-1017 and 1-1019(1)) – The two doors leading into this locker room are not equipped with locks. The large room contained lockers and 2 bathrooms, each with a shower.

Mechanical Room (1-1023) – The door was equipped with a lock, and it was engaged, but the door was not fully closed and therefore the room was not secured to restrict unsupervised access by residents. This room contained compressors, emergency power panels, and boxes of maintenance related items such as door knobs and brackets. While the inspector was observing the room, the home's Manager of Housekeeping, Maintenance and Laundry Services came along, and confirmed the expectation that this door should be fully closed and locked when not supervised.

Staff washroom (1-1026) – The door was not equipped with a lock. The inspector found the door wide open, and the light on.

Laundry room (1-1070) – The door was equipped with a lock, it was engaged, but the door was not fully closed and therefore the room was not secured to restrict unsupervised access by residents. This room contained washers and dryers, other related laundry equipment, buckets of laundry chemicals, a 4 Litre jugs of EcoLab Ultra San warewashing sanitizer and destainer on top of the buckets, and 3 more jugs of this product in a box next to the buckets. While the Inspector was in the room, laundry staff #S140 came into the room and confirmed that this door is supposed to be kept fully closed and locked when the area is not attended.

Soiled laundry room (1-1068) – The door was equipped with a lock, but the door was not closed or locked in order to prevent unsupervised access to the area by residents. The room contained laundry carts.

Housekeeping area (2-100) – The doors leading to this non-residential area are not equipped with a lock. The inspector found the following within the area:

a) Door #2-107 was open, this door leads to an area which contained a storage room, mainly for decorations (#2-109). Door #2-107 was not equipped with a lock that would prevent unauthorized access. Also in this area was a door that leads to a secured outdoor space (#2-110), which was not equipped with a lock.

b) Door #2-106 was open. This door leads to the housekeeping supervisor room. A sign on the door reads " this door must remain closed and locked. Contact Housekeeping Supervisor for admittance". This room contained stocked housekeeping carts and a variety of housekeeping equipment, supplies and cleaning products. Door #2-106A within this area was open, and this lead to a room that contained a large variety of cleaning products including polishes, cleansers and disinfectants.

At 2:04pm, while still in the housekeeping supervisor room, the Inspector contacted the ESM and reported these observations. The ESM arrived to the area promptly and stated that door #2-107 is to be closed and the thumb slide bolt on the door engaged when the area is not supervised. As well, door #2-106 is to be closed and locked without exception when the area is not supervised.

The inspector returned to this area at 6:41pm and again found that door #2-106, leading to the housekeeping supervisor room, was not closed and locked. There were no staff present in the area at the time of observation. The door leading to the main cleaning product storage room, #2-106A, was closed and locked at this time.

On September 9th, 2014, the Manager of Housekeeping, Laundry and Maintenance (the Manager) informed the inspector that the door leading into the housekeeping area, #2-100, was going to be locked. The Manager indicated that the work had started, and this was observed by the inspector.

ii) The following resident accessible doors leading to non-residential areas, on

the 3rd, 4th and 5th floor care units, were noted to be non-compliant at the time of observation. The resident-staff communication and response system was not available in any of the noted areas, as is required in all areas that residents have access to. Staff were not present and supervising the noted areas at the time of observation.

On September 8th, at approximately 3:38pm, Inspector #133 observed that door #1- 1512A, leading into the dishwashing, food preparation and food storage area within the Sydenham dining room, was not fully closed and locked. The door was equipped with a lock. It was noted that within the room, there was a coffee maker that included a red spigot that dispensed hot water that that was steaming when emptied into a cup by the Inspector. As well, there was a spray bottle of Oasis 146 Multi Quat Sanitizer at the single dish sink. A Personal Support Worker (PSW) , Staff #141, came into the dining room while the Inspector was observing the back service area. The PSW explained that the while the door is supposed to be kept closed and locked when not supervised, it is not always kept that way because they (PSWs) regularly need access to the items within, and only dietary staff and registered nursing staff have a key.

Inspector #133 returned to the Sydenham 5 dining room at 6:11pm on September 8th, 2014, and again found that door #1-1512A was not closed and locked. There were two residents in the dining room. There were no staff supervising the area. Inspector #133 returned to the Sydenham dining room at 2:21pm on September 9th, and again found that door #1-1512A was not locked. There were no staff supervising the area. On September 10th, 2014, at 3:36, the inspector again observed that this door was not locked. The inspector found a thermometer in the server and measured the temperature coming out of the red spigot on the coffee maker at 150F/65C. Residents are not to have access to water that is above 49C, due to risk of scalding. There were no staff supervising the area.

On September 8th, 2014, at 5:15, Inspector #133 observed that the door leading into linen room #1-3082 was open, and no staff were in the area supervising the door. The room contained shelving carts, on which there was resident care products such as briefs, gloves, cavi disinfectant wipes, and clean linens. The door was equipped with a lock, but it was not kept closed and locked in order to restrict unsupervised access to the area by residents.

On September 8th, 2014, at approximately 9:30am, Inspector # 197 observed a

clean utility room door propped open. This was observed on the 5th floor, within the Sydenham unit. The room was noted to contain briefs, clean linens and resident care products such as disposable razors, and mouthwash. There were no staff in the area supervising the door at the time of observation. The door was equipped with a lock, but it was not kept closed and locked in order to restrict unsupervised access to the area by residents.

On September 3rd, 2014, at approximately 10 am, Inspector #531 observed a clean utility room door that was not closed and locked, on the Montreal 4 unit. The door was noted to be equipped with a lock. Within the same time period on that day, Inspector #531 also observed that the door to a housekeeping room that contains an eye wash station on Montreal 4 was unlocked. It was noted that within the room, there was a cabinet, with a key in the door, that held cleaning supplies such as a disinfectant cleaner, a window cleaner, odour control pellets, and bottles of purell. The door was equipped with a lock, but it was not kept closed and locked in order to restrict unsupervised access to the area by residents.

On September 8th, 2014, at 9:30am, Inspector #531 observed the clean utility room door propped open on the Sydenham 4 unit. Within the room, inspector #531 observed supplies of mouthwash, body lotions, body wash, razors and roll on deodorant. The door was equipped with a lock, but it was not kept closed and locked in order to restrict unsupervised access to the area by residents.

On September 11, 2014, at 10:22am, Inspector #133 observed a clean utility room on Sydenham 4 wide open (#1-4005). The room contained briefs, linens, personal care products, and gloves. The door was equipped with a lock, but it was not kept closed and locked in order to restrict unsupervised access to the area by residents.

On September 11, 2014, at 10:26am, Inspector #133 observed that the Laundromat within the Montreal 4 unit, #1-4024, was not locked. The door is not equipped with a lock that can prevent unauthorized entry. There is a small slide latch on the top of the door. The room contains a washing machine dedicated to laundering slings, and a dryer.

On September 11, 2014, at 10:30am, Inspector #133 observed an empty room , #1-4033, within the Montreal 4 Unit. Staff in the area informed this room is for storing the vacuum and dust mops. The door is not equipped with a lock that can

prevent unauthorized entry. There is a small slide latch on the top of the door.

On September 11, 2014, at 10:40am, Inspector #133 observed Housekeeping Room #1-4094, within Montreal 4, was not locked. The room contained a floor buffer and a mop bucket in a sink. The door was equipped with a lock, but it was not kept closed and locked in order to restrict unsupervised access to the area by residents. It was noted that the door would not close under its own weight. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 15, 2014

Order # / Ordre no : 004

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 :

In order to achieve compliance with O. Reg. 79/10, s. 9 (1) 1. i., the licensee will ensure the following:
a) That all resident accessible stairway doors on the 1st floor are equipped with a lock so that these doors can be kept locked at all times.
As well, the licensee will equip all such doors with a door access control system, as per O. Reg. 79/10, s. 9 (1) 1. ii.
Until such time that the licensee is in full compliance with O. Reg. 79/10, s. 9 (1) 1. i, formalized measures shall be taken to ensure resident safety in relation to their unrestricted access to stairways from the 1st floor and unrestricted access to doors that lead to the outside of the home, within the stairways, that are not alarmed.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1. i. in that the licensee has failed to ensure that resident accessible doors leading to stairways, throughout the 1st floor, are kept closed and locked.

The widespread non-compliance described below presents a potential risk to residents, particularly to those who travel independently down to the home's 1st floor.

On September 8th, 2014, Inspector #133 went down to the home's first floor via the elevator in the main entrance area. It is noted that both the Montreal and Sydenham elevators go down to the 1st floor. It is noted that resident access to the elevators is restricted on the 5th floor care units. The Inspector spoke with staff in the attendant care outreach program office. Staff # S107 confirmed that residents do come down to the 1st floor and its not unusual that staff reorient residents to the direction they are to go in in order to access resident areas, such as the auditorium. Staff # S107 said "they (residents) can get turned around, it's like a maze down here". This notion was reiterated by a member of the activity department, #S108, on August 9th, 2014. While discussing resident activities held in the Auditorium, and how residents get down to the 1st floor, staff #S108 indicated that "it can be like a maze down here for the residents, especially if they come down the Sydenham elevators".

In addition to attending activities within the Auditorium, residents may also go to the 1st floor in order to access the secured garden space, the Haughian Garden; to meet up with groups for bus outings; and to view the lost and found cart near the laundry services areas, which is also in the area of the Haughian Garden.

On September 8th, 2014, Inspector #133 met resident #41on the 1st floor, in the area of Locker Room A, which is to the right and down the hallway from the Sydenham elevators. The resident asked the inspector where they should go to find the bus group. A few minutes later, a recreation staff member, #S109 came along and explained to the Inspector that the bus pick up area was around the corner and down the hall past all of the kitchen service areas, at the ambulance services doors. The staff person explained that Resident #41 had come down earlier than needed as the group wasn't to meet for another 10 minutes. Staff #S109 and Resident #41 went together to the bus area.

Throughout the 1st floor, the Inspector noted seven resident accessible doors leading to stairways that are not equipped with a lock (stairwell #1 - #7). As well, these doors are not equipped with a door access control system, nor are they alarmed, as is required by O. Reg. 79/10, s. 9 (1) 1. ii. and iii.

It is noted that within each of the seven stairways, on level 1, there is a locked exit door leading to the outside of the home. Because the preceding doors were not secured at the time of the inspection, these exit doors are seen as resident accessible doors that lead to the outside of the home, to which O. Reg. 79/10, s. 9 (1) 1. iii. applies, related to alarms. Stairway 3 is a noted exception. There is no alarm in place on the exit doors within stairway 1,2,4,5 and 7, which are only released in the event of a fire alarm. It was thought there was a form of alarm on the exit door within stairway #6, which is in the immediate are of the Sydenham elevator. On September 10th, 2014, the Manager of Housekeeping, Laundry and Maintenance Services and Inspector #133 determined that while there was a functional alarm at the door in the past, it was not functional at the time of the inspection.

There is no notification to staff if any of the exit doors that lead to the outside of the home, within the unsecured resident accessible stairways, throughout the 1st level, fail to close securely after being accessed. This further elevates risk to residents related to the unlocked stairway doors.
(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 16, 2015

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 : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee must correct the extensive list of items identified below which support this
Compliance Order.

The licensee must develop and implement an effective system of ongoing auditing to ensure that all maintenance issues identified by this auditing system are corrected promptly.

The licensee must ensure that the maintenance program is organized and effective in meeting the overall maintenance needs of the home.

The licensee will ensure schedules and procedures are in place for remedial maintenance as per O. Reg. 79/10 s. 90 (1) (b). These schedules and procedures must be written as per O. Reg. 79/10 s. 30 (1) 1.

Grounds / Motifs :

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

On September 10th, 2014, Inspector #133 observed the 3 Sydenham dining rooms. Each dining room can be said to have 3 distinct sections. The section to the right of the servery (when facing it) will be referred to as section C, mid areas as section B, and area to the left of the servery as section A. In general, lower walls throughout sections A and B were noted to be in very poor repair. Areas throughout these sections were extensively scuffed and deeply gouged. At corners, such as on the post across from the windows in section A, and within areas between sections A and B, paint and drywall have been broken away, exposing the metal strapping beneath. This disrepair was also noted in the C sections, yet not to the degree and extent of what was seen in sections A and B.

Over the course of Inspector #133's active inspection period at the home, September 8th-11th, 2014, many heavily stained ceiling tiles were observed, throughout all areas of the home.

In the following areas, one or more ceiling tiles were notably stained, typically light and/or dark brown in colour, in a large section of the tile or in multiple sections within a tile: McKinley room, closer to the servery area, above a bulkhead; Montreal 2 elevator area; Sydenham 5 dining room, within the seating area to the left of the servery, next to one of the vents; Montreal 5 Dining Room, above the speaker; in hallway outside of room #1-5085; in hallway, above fan, outside of bedrooms #576 and #575; Tub room #1-3037, throughout the room and above toilet, where tile had sagged and cracked and was very heavily stained; Tub room #1-3018, throughout the room; Tub room closest to bedroom #309; Shower room #1-3087; 1st floor – locker room A; Hallway at bedroom 441; Montreal 4 dining room, in front of server; Montreal 4 resident washroom (#1-4059), above toilet; Sydenham 4 resident washroom #1-4004

In the following areas, stained ceiling tiles were also noted to have concentrated black centers or definitive black areas within the stained section, which was suggestive of mold growth: McKinley room, in the area of the piano and in the area of the fireplace; Sydenham 5 dining room above the hand sink and in the area of table 3 and 4; Sydenham 3 Tub Room #1-3018; in hallway outside of bedroom #547; Tub room #1-3018; 1st floor – hallway at room #1-1035, #1-1039, Locker room B.

On September 11th, 2014, in the area of housekeeping room #1-4095, in the Montreal 4 unit, there was a large ceiling tile in pieces on the floor. The pieces of tile were very heavily stained and warped. There was a small white bucket in the

area. There was nothing in the bucket.

Montreal 5 dining room – continuous area along bulkhead at windows that face Bay Street was stained, paint had chipped and peeled away within the affected area;

Tub Room #1-3037 – lower wall extensively damaged (deeply gouged, drywall down to metal strapping beneath);

Tub Room #1-3018 – lower wall extensively damaged (deeply gouged, drywall down to metal strapping); 1st floor – lower walls from the Sydenham elevator area down hallway around the Montreal elevator area were extensively damaged (areas are very deeply gouged, corners are down to metal strapping beneath drywall);

On September 9, 2014, Resident #41 showed Inspector #133 damage within their bedroom. The resident pointed out floor gouges, in front of their dresser and closet and bedside table. The resident told the inspector that these gouges had been in the room when they moved in, and that they had been told that the floor would be repaired. The resident said they were embarrassed about the gouges, and was always sure to tell visitors that they were not made by them. The resident pointed out that they have put a mat over the gouges at the bedside table in order to hide them, and that they would like to get some white paint so they could fill in the gouges to obscure them from view. Resident #41 pointed out to the inspector a large area on the ceiling in their bed area that had leaked, resulting in peeling paint and plaster. The resident said he/she was told the ceiling would be repaired when the area dried up, and said "its been like this for about a month and a half, and it must be dry by now". The resident pointed out another damaged area, the ceiling above the doorway. The area is stained and peeled. Resident #41 explained that a month or two ago, there was water leaking down through the light fixture and around the light fixture (upon entry to the room). Resident #41 said this caused them great alarm, and the light switch has since been taped in the off position in an effort to ensure it is not activated. Resident #41 said they were told that a pipe had burst within the ceiling space in the area of the fixture.

Resident #41 said to the Inspector "They have a lot of catching up to do in this building, I can see that everywhere I go".

Sydenham 5 – pillar in front of nurses' station were deeply gouged throughout lower section with a hole in it.

Tub room on Montreal 4 care unit (#1-4036) – lower wall next to tub in very poor repair, areas deeply gouged and scuffed, with holes, and area at the sink damaged to expose metal strapping on corners.

Resident bathroom on Montreal 4 care unit (#1-4059) – walls extensively damaged, deeply gouged next to toilet and damaged to expose metal strapping at corners in two areas.

Inspectors observed additional examples as follows:

-Resident #39's bedroom has large areas of scuffs noted on left wall as entering room, there are numerous gouges in floor of bedroom at foot of bed and below window and window side of bed. The shared bathroom has rust noted around edges of sink, the finish on drain is missing and there is rust noted at the base of the faucet on the sink (103)
-Resident #14's bathroom sink has rust noted around the edge of the sink at the countertop, there is a buildup of dirt at the base of the toilet at the floor edge and scarring of paint at the bottom edges of door frames going into bathroom as well as on the base of the bathroom door. The light fixture as you enter the bedroom is missing a light cover (103),
-Resident #22's sink in the bathroom is rusted and missing finish (103),
- Resident #19's sink is rusted and missing finish (103),
-Resident #33's sink in the bathroom is rusted and missing finish (103),
-Resident #26's sink in the bathroom is missing finish (103),
-Resident #2's bathroom sink is rusty (103),
-the whirlpool located across from Room #360 has a yellow discolouration on the floor by tub and at the base of the toilet. There is a build up of debris at the tub edge and the rubber sealing on the tub is pulled away from the tub. The tub surface is scarred at the corner, the sink is rusted and the floor rad is missing paint. There is yellow staining on ceiling tile above toilet and a large open hole is present under the sink exposing the pipes for the tub (103),
-the shower room located across from Room #309- the sink is rusted and missing finish, flooring going into shower area is lifting/missing, there are large areas of missing/gouged paint on walls/doors, the shower chair back made of a webbing material is discoloured with a yellow/brown staining (103),
-the whirlpool located across from Room #332 has a hole and a large area of

missing/gouged paint on the wall on the right as you enter the room by tub, the sink is rusty and missing finish, the counter top is missing finish and there are areas on the wall missing plaster down to metal strapping. The storage dresser beside the tub has finish missing and the ceiling has yellowed tiles/holes from what appears to be water damage (103),
- Montreal 4 fireplace/tv room-the pillars are scuffed, the walls have drywall damage and chipped paint (531),
-Montreal 4-multiple drywall repair areas patched but unpainted by the elevator (531),
-Montreal 4-floral high wing back chair located in resident common area has scuffed legs and chipped/worn wooden arms (531),
-Resident #40's bedroom floor is scarred with a large area of black scuffs, the bedside table is chipped/worn and the base wood is peeling (531),
- Resident #24 has no toilet in the shared bathroom; only a commode (197),
-Resident #3's bathroom has black scuffs over the lower areas of the walls with black scuff marks (531),
- Resident #21's bedroom has multiple black scuff marks on the floor, the drywall is missing on corners, paint and corkboard is missing along the bottom of the clothes closet doors; the door frames including the bathroom entrance door is missing large areas of drywall. The electric outlet in the wall behind the chair by the bedside table has two plugs plugged in, but there is no electrical cover. This resident's shared bathroom has a large hole in the drywall by the sink. Resident #21 told this inspector that he/she has asked for the areas to be repaired and painted a number of months ago, but feels they only do that when another resident moves into the room (531),
- Resident #10's bedroom has multiple long black scuff marks on the entrance way, washroom door, and along both walls; there is chipped/cracked paint on the doors and rubber seal top of the door is falling off (531),
-Resident #22's bedroom has large areas of scuffs on the wall at the foot of bed, the baseboard is pulled away from the wall and there are gouges on the floor by the night stand. There are areas of plaster missing on the corner going into the bathroom down to the metal strapping and also at closet and there is scuffing across the bathroom door (103),
- the small ante/common area located outside of the Montreal 3 dining area-there is a large area on the wall that is heavily scuffed with plaster chipped and paint missing (103),
- Resident #24's bedroom has heavy scarring on the bedroom and bathroom doors as well as walls around closet and bathroom doors. Large pieces of drywall/plaster missing (197),

-Resident #33's bathroom has missing paint on the bathroom doors and the frame of the door (103),
-Resident #15's bedroom wall on the right side of the room is scuffed with black marks (531), and
-the Sydenham elevator has large areas of missing paint.

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 16, 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 16th day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

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