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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 13, 2016	2016_346133_0025	010213-16	Follow up

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 6-9th, 2016.

This Follow Up Inspection was related to a Compliance Order, issued to the licensee in December 2015, related to the maintenance of the home. The compliance order was reissued as a result of the inspection.

During the course of the inspection, the inspector(s) spoke with the Facilities Manager, the Director of Care, maintenance workers, registered and non registered nursing staff, and some residents.

The inspector reviewed documentation, as provided by the Facilities Manager, relating to actions taken in response to the Compliance Order. This included a 15 page document titled "REPORT 2015 – 2016 MOHLTC", which included the new remedial maintenance policy #CARE-EM-8, an example of a bedroom audit task ticket generated by the maintenance program, an example of a common area audit task ticket generated by the maintenance program, a printout of the maintenance work done in relation to repair or replacement of non-functional lights, and a printout of the maintenance work done in relation to remedial maintenance, which corresponded with the examples of disrepair captured within the Compliance Order. As well, the inspector observed resident bedrooms and common areas throughout the home, with a focus on the state of repair of observed areas and items.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c) in that the licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has a history of non-compliance with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c). On September 16, 2014, as a result of Resident Quality Inspection (RQI) #2014_179103_0024, the licensee was served with Compliance Order (CO) #005, with a compliance date of March 16th, 2015. As a result of follow up to CO #005, over the course of the following RQI, #2015_444602_0034, the CO (#005) was closed and linked to a subsequent CO (#001), as it could not be complied. The licensee was served with CO #001 on December 21, 2015 by Inspector #197. The original compliance date for CO #001 was April 30th, 2016. On April 29th, 2016, the compliance date for CO#001 was extended to June 3rd, 2016, by Inspector #133, upon request from the licensee.

In addition, Inspector #133 conducted an "Other" inspection at the home on March 7-9, 2016 (#2016_346133_0012). Over the course of the inspection, 37 examples of one or more non-functional lights in identified areas were noted. The licensee was issued a Written Notification as a result, pursuant to LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c). The finding of non-compliance was issued as additional evidence in support of CO #001.

CO #001 directed the licensee as follows:

"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 develop, implement and maintain a scheduled preventative maintenance and repair program that includes a regular audit of the home to identify areas that are in need of repair and to ensure that required maintenance, repairs and service issues are corrected promptly. The licensee will ensure written schedules and procedures are in place for remedial maintenance as per O. Reg. 79/10, s. 30 (1) 1".

On June 7th, 2016, Inspector #133 met with the Facilities Manager (FM). The FM explained that due to financial constraints, the decision was made to focus maintenance resources exclusively on addressing the examples of disrepair that were noted by Inspector # 197 in the grounds that supported CO #001, as opposed to trying to fix everything. As well, all examples of non-functional lights, as per inspection

#2016_346133_0012, had been addressed. The FM elaborated that a full audit of the home had been conducted after that inspection, focused on the functionality of lights, and that all identified deficiencies had been corrected.

Relating to the requirement within CO #001 for the licensee to establish a "regular audit of the home to identify areas that are in need of repair and to ensure that required maintenance, repairs and service issues are corrected promptly", the FM explained that an annual audit process for the home had been developed. The FM explained that over the year, the audit process would reveal the additional remedial maintenance needs of the home. On June 9th, 2016, the FM informed that the audit process for resident bedrooms started in February 2016. To date, 86 of the 243 bedrooms had been audited. The bedroom audits had led to the creation on 78 new maintenance tickets. The FM informed that none of the 78 new maintenance tickets had been actioned, to date. The audit process for common areas on the care units was to have begun at the beginning of June 2016. The FM explained that when a plan was developed to address the maintenance issues identified by the audits, the first ticket that was created, in February 2016, would be the first ticket to be addressed.

As such, there were no schedules in place for remedial maintenance and the maintenance program was not organized to ensure that all required maintenance, repairs and service issues are corrected promptly.

On June 13th, 2016, following the conclusion of the onsite Follow Up inspection, the FM called the Inspector and informed that beginning at the end of June 2016, the two maintenance workers would be dedicated to the remedial maintenance needs of the home, two days per week. The FM indicated that this had been planned prior to the Follow Up inspection, yet he had forgotten to inform the Inspector during the onsite inspection.

Over the course of the Follow Up inspection, June 6th – 9th, 2016, Inspector #133 confirmed that all of the examples of disrepair that were noted by Inspector # 197 in the finding of non-compliance that supported CO #001 had been addressed. As well, it was verified that all examples of non-functional lights, as per inspection #2016_346133_0012, had been addressed.

Over the course of the inspection, Inspector #133 noted widespread examples of poor repair throughout the home, the majority of which was in areas that had not been referenced in CO #001.

Related to bedroom lights:

Over the course of the inspection it was noted that the cover (the lens) for the square, flush mounted, ceiling light fixture within the immediate entrance area of forty four observed resident bedrooms was missing. The bedrooms in issue are as follows: 576, 572, 570, 514, 516, 517,519, 522, 524, 531, 534,536,538, 543, 547, 549, 551, 552, 553, 560, 565, 562, 330, 341, 343, 350, 348, 301,302, 366, 376, 443,449, 452, 416, 432, 458, 465, 467,469,474,476,477 and 483. In five bedrooms, identified below, a non-functional light was observed.

The ceiling light fixtures are designed to have a cover (lens). On June 8th, 2016, resident #002, in bedroom #452, told the Inspector that he/she found there was a glare from the light due to the missing cover. The FM acknowledged the missing covers, and explained to the Inspector that they can no longer find replacement covers, so they have to have them made, or change the fixture. The FM indicated that, as this was not a safety issue, maintenance resources were not being allocated. On June 9th, 2016, the Inspector had observed, in bedrooms M-435 and M-448, that there was a clear textured cover on the entrance light fixtures, held in place with clear tape on the outer perimeter of the fixture. In all previous cases, where there was a cover observed, it was smooth and opaque, and fit into the inner perimeter of the fixture to cover the fluorescent bulb. The FM was unsure if the home had cut and affixed these two unique covers, and indicated the Inspector would have to check with the maintenance workers. The Inspector spoke with the two maintenance workers who are tasked with remedial maintenance duties, and neither could recall having creating these covers.

In bedroom S - 520, on June 7th, 2016, it was observed that the lower light in the over bed fixture was not functional.

In bedroom M-550, on June 7th, 2016, it was observed that the ceiling mounted light within the entrance of the room was not functional.

In bedroom M-328, on June 8th, 2016, it was observed that the lower light in the over bed fixture was not functional.

In bedroom S-417, on June 9th, 2016, it was observed that the upper light in the over bed fixture was not functional.

In bedroom M-458, on June 9th, 2016, it was observed that the light switch for the top light in the over bed light fixture was missing and therefore the top light could not be turned on.

Related to baseboard radiators:

Over the course of the inspection, it was noted that a length of radiator cover, ranging from one and a half inches to three and a half inches, was missing from ten observed areas. As a result, the sharp metal radiator fins were exposed, in a central area of the radiator. The areas in issues are as follows: S5 welcome room, S - 513, M5 dining room, M3 dining room, M- 327, M-337, M – 339, S – 313, S – 317 and M – 431.

Related to shelves above toilets:

Over the course of the inspection, it was noted that the shelving was in very poor repair in sixteen observed resident bathrooms. The laminate surface was worn or broken away along the length of the front edge of the shelves, up to one and a half inches in width, and in some cases also along the back edge and also within the central area. The absorbent particle board subsurface was exposed and swollen and, in some cases, crumbling. Such surfaces cannot be cleaned or disinfected, and they are located directly above the toilets. The shared bathrooms in issue are as follows: M-523/524, M-529/531, M-533/535, M-537/539, M-555/557, M-558/559, M-324/323, M-331/329, M-325/327, M-329/331, M-333/335, S-302/304, S-306/308, S-317/319, S-318/320 and M-433/435.

Related to bedroom S-514:

As observed on June 7th, 2016, the toilet seat and the raised arms attached to the seat were not securely affixed to the toilet bowl and moved freely from side to side. The top and sides of the left arm rest were broken and there were sharp plastic edges around the perimeter. The two exposed screws that held the plastic onto the metal frame were raised.

On June 7th, 2016, A Personal Support Worker, PSW #S101, told the Inspector that the toilet had been in such a condition since March 2016. The PSW indicated that the issue had been reported. PSW #S101 told the Inspector that resident #001 was taken to a nearby common bathroom to be toileted, due to the potential risk.

On June 8th, 2016, the Facilities Manager (FM) informed that the condition of the

resident #001's toilet had been reported via the maintenance reporting system on May 5th, 2016. The FM explained that the maintenance workers had been focused on addressing the issues identified in CO #001, and that the ticket related to #514 had not yet been actioned. The seat was securely affixed to the bowl, and the damaged arms were removed, on June 8th, 2016.

Related to bedroom S-520:

As observed on June 7th, 2016, behind the resident's bed, the wood panel in place to protect the wall from damage had detached from the metal strip that had held it in place. The right side of the panel was being held up by the strip as it was stuck in it and the left side bottom corner was resting on the floor. The metal strip was not flush with the wall and the left side of it was raised upwards. The corner edge of the left side of the strip was sharp, and it was close behind the very top of the headboard.

At the inspector's request, the Registered Nurse (RN) on the unit, #S102, accompanied the Inspector into the bedroom. The RN indicated that she had not been aware of the problem, and agreed that it was a potential safety risk. The RN and the Inspector lifted the panel off the metal strip and rested it, upright, on the floor behind the bed. The RN brought in a towel and tucked it all around the left corner edge of the metal strip. The RN indicated she would report the issue immediately.

On June 8th, 2016, the FM confirmed that RN #S102 had reported the safety issue, via the maintenance reporting system, the previous day. The FM directed maintenance staff to re-affix the wood panel behind the bed on June 8th, 2016.

2. The following additional examples of observed poor repair, in resident bedrooms, bathrooms, and common areas, predominantly detail the condition of walls, floors and sinks. It is to be noted that the Inspector observed the majority of bedrooms and common areas on the 5th and 3rd floors. Observations on the 4th floor were generally exclusive to areas noted in CO#001 and some common areas. Some additional 4th floor bedrooms were partially observed, mainly from the hallway, if the door was open as the inspector passed by.

Sydenham 5 unit:

- Tub and shower room across from bedroom #508 - The corner of the wall between the

shower stall and the door leading into the toilet room was damaged in two distinct areas, whereby the paint and drywall had broken away and the metal strapping beneath was exposed. The lower area was approximately 9.5 inches in length and 2.5 inches in width in the widest section. The top area was approximately 8.5 inches in length and 4.5 inches in width in the widest section.

The floor seam along the shower stall sill was not intact (48 inch length) and at the corner closest to the shower faucet, the flooring was slightly raised as it was not adhered to the sub surface. In that corner, a section of flooring measuring approximately 6.5 inches by 1.5 inches was missing.

The wall next to the tub, around the electrical outlet for the fan and the lift charger, was extensively gouged.

In the bathroom, the wall underneath the soap dispenser was worn down to the drywall, along the top of the sink counter, and the paint above it was chipping and peeling.

There was a ceiling tile above the sink that had a brown semi-circle stain on it.

- S5 Dining room, side opposite nurses' station - At table #2, on the lower wall to the right, there was a circular area where the paint had been peeled away, measuring approximately 4 inches by 2.5 inches. At table #2, on the lower wall to the left, there was an area where the paint was peeling and the drywall was gouged.

Within the servery, there were two ceiling tiles that had brown circular stains on them, one above the fridge and the other closer to the hand sink.

- S5 Dining room, side opposite the elevator - The lower wall between the first and second tables along the wall that faces the hallway was in very poor repair. The lower portion of the column between the tables was extensively worn and the metal strapping on the left front side was exposed, area of approximately 7.5 inches by 3 inches. The lower wall, between the column and the second tables, was worn down to drywall in a patch approximately 21 inches in length and 3 inches in width, with a smaller worn area closer to the second table. There was a 12 inch by 2 inch area in the lower wall, upon entry to the room, where the drywall was crumbling and broken into small chunks.

- Bedroom 505 - The floor, in front of the bed side table, was gouged. The floor, at the foot of the bed was more extensively gouged. There was accumulation of dark matter

within the gouge lines. An 8.5 inch length of floor seam, at the side of the bed, was not intact.

- Bedroom 507 - The lower wall across from the bed was in poor repair in that along a 30 inch length the paint was peeling and chipping away, with some areas within that were worn down to the drywall.

- Bedroom 583 – The upper wall was deeply gouged in small areas all around the lower portion of the hand sanitizer dispenser. The lower wall, to the right of the inner bedroom door frame was in poor repair in that there was horizontal strip where the paint had peeled and the wall was gouged.

The floor, in front of the bed side table, was extensively gouged. There was accumulation of dark matter within the gouge lines.

- Bedroom 581 – The lower wall across from the foot of the bed was in poor repair whereby there was a 14 inch horizontal length along which the paint had peeled and some areas were worn down to the drywall.

The floor, between the foot of the bed and the wall, was gouged. There was accumulation of dark matter within the gouge lines.

- Bedroom 577 – The floor in front of the rolling over bed table and the high backed comfortable easy chair was gouged. The floor between the foot of the bed and the table across from the bed was extensively gouged. There was accumulation of dark matter within the gouge lines.

- Bedroom 575 – The floor, in front of the bed side table, was extensively gouged, with accumulation of black matter within the gouge lines.

- Bedroom 572 – The toilet seat was loose; it could be moved freely from side to side.

- Bedroom 567 – The lower wall next to the toilet was in poor repair in that the paint was cracked, peeled down to the drywall and the area above the baseboard was damp, with one small blackened area.

- Bedroom 570 - The lower wall to the right of the bathroom door was in poor repair in that the area was scraped, gouged and the corner metal strapping was exposed. The

lower wall across from the bed was in poor repair in that there was a 29 inch horizontal length along which the paint was cracked or worn down to the drywall.

The floor, at the foot of the bed, was gouged, with accumulation of black matter within the gouge lines.

- Bedroom 571 – The wall across from the bed was extensively gouged, scraped and peeling. To the left of the closet, the corner metal strapping was exposed on both sides.

- Resident bathroom across from the S5 dining room – The wall next to the toilet was gouged and pitted.

- S5 tub room, across from #522 – The lower wall upon entry, to the right of the tub, was gouged along a 5 inch length and the paint was scraped and peeling below the gouged area. The metal strapping was exposed along both sides of the wall at the sink (11 and 19 inches in length, 1 inch to 1.5 inches in width).The edge of the metal strapping was exposed along the lower corner of the wall next to the tub.

- Bedroom 513 – The lower wall immediately above the baseboard, to the right of the bathroom door, was in poor repair as there was a 4 inch length of drywall that was gouged and crumbled, and the metal strapping was exposed.

- Bedroom 514 – The lower outer bathroom door was in poor repair as it was extensively scraped and scuffed with black marks throughout as was the lower outer door frame, and lower wall, to the left of the bathroom door. The wall across from the foot of the bed was extensively scuffed with black marks and scraped and areas were worn down to the drywall. The lower inner bathroom door was extensively scuffed with black marks and the door frame was scraped down to the metal in areas.

- Bedroom 517 - The floor was pitted and gouged in an area at the head of the bed, with accumulation of dark matter within the gouges. The floor was cracked apart in two other areas. The larger cracked area was approximately 23 inches by 10 inches and the smaller cracked area was approximately 11 inches by 9 inches.

- Bedroom 518 – The lower wall across from the bed was scuffed with black marks, scraped and it was worn down to the drywall in three distinct circular areas.

In the shared bathroom, there was no cover for the toilet tank. The lower door, leading

into #518, and the lower wall to the right of the door, was scuffed with black marks. There was an area, just above the baseboard, to the right of the door leading into #518, where the paint was peeled and cracked and there was an accumulation of black matter. The lower door, leading into #520 was extensively scuffed with black marks and the door frame was scraped down to the metal.

The floor, in front of the bed side table, was pitted. The floor, in front of the corner table was gouged. There with accumulation of dark matter within the gouges and pits.

- Bedroom 520 – The lower outer right bathroom door frame was scraped down to the metal in areas, the lower outer bathroom door was scuffed with black marks and the lower corner of the wall to the left of the bathroom door was damaged and the metal strapping was exposed.

Montreal 5 unit:

- Bedroom 523 – The baseboard behind the bed was not adhered to the wall and was resting on the floor. There was no baseboard on the wall to the left of the bathroom door. In the bathroom, shared with #524, there was no baseboard on the wall behind the toilet and there was no baseboard on the wall under the sink.

- Bedroom 526 – The floor in front of the bedside table was extensively gouged, with accumulation of dark matter within the gouge lines.

- M5 tub room, across from bedroom 532 – The lower wall, to the right of the tub, was scraped, peeling and gouged in areas with a circular hole above the door stop, with chunks of crumbled drywall within it. The corners of the wall at the sink were in very poor repair, the drywall was broken off and the metal strapping was exposed, in lengths of approximately 47 inches on both sides.

The corner metal strapping was exposed along the corner of the wall under the sink.

Montreal 5 nurses station – One ceiling tile next to light fixture was stained pink and orange in a semi-circular area.

- Bedroom 546 – There was a hole in the ceiling next to the access panel, above the head of the bed. The outer perimeter of the hole was discolored and the paint around the perimeter of the hole was peeling.

- Bedroom 550 - The lower wall across from the foot of the bed was scuffed with black marks and the paint worn down to drywall in areas

- Bedroom 554 – The lower wall across from bed #1 was scuffed with black marks, scraped and worn down to drywall within areas. The lower corner of the wall to the right of the area described above was worn down and the metal strapping was exposed.

- Bedroom 558 - The floor in front of the dresser was gouged at the floor in front of the bedside table was extensively gouged, with accumulation of black matter within the gouge lines.

Montreal 3 unit:

- Bedroom 331 – The lower corner metal strapping was exposed, on the wall to the left of the closet. The lower corner metal strapping was exposed, on the wall to the left of the bathroom door.

- Resident bathroom in the area of the M3 nurses station – There was a ceiling tile with a brown circular stain above the toilet.

The lower wall to the right of the toilet was in poor repair in that a patch of drywall had broken off and the corner metal strapping was exposed and the paint around the area was peeling. (6.5 inches by 1 ¼ inches)

- M3 tub room, across from bedroom 361 – The toilet paper holder was missing from the wall next to the toilet and there was a bucket with rolls of toilet paper in it.

- Bedroom 325 – The lower right bathroom door frame was scraped down to the metal and drywall on the lower corner of the wall to the right of the bathroom door was broken off to expose the metal strapping (area was 8 inches long and 5.5 inches wide in the widest section).

- Bedroom 327 – There was a hole in the wall under the window, approximately 4 inches by 6 inches.

- Bedroom 328 – The outer lower bathroom door was scuffed with black marks. The wall to the left was scuffed with black marks, scraped and gouged. The lower left corner was

broken down to the metal strapping. The corner to the right of the bathroom door, next to the bed side table, was broken to expose a 19 inch length of metal strapping.

- Bedroom 332 – The metal strapping was exposed along the corner of the wall to the right of the bathroom door. The lower outer bathroom door was scuffed with black marks, scraped and gouged and the door frames were scraped down to the metal on both sides.

- Bedroom 337 – The right bathroom door frame was scraped down to the metal and the edge of the metal strapping was exposed along the corner to the right of the bathroom door.

In the shared bathroom, the inner door that leads into 337 was extensively scuffed with black marks and the frame on both sides was scraped down to the metal. The inner door that leads into 339 was in a similar condition, but to a lesser degree.

- M3 staff bathroom – The wall under the soap dispenser was in very poor repair. There was extensive moisture damage. The outer wall surface has worn away and there was an area of brown hard porous matter, with accumulation of white matter around the area. This bathroom was observed upon request from nursing staff. A Personal Support Worker, #S103, informed that a maintenance ticket had been completed for this issue for the first time approximately one to two years ago and most recently, six months ago.

- Bedroom 352 – In the shared bathroom, the inner door that leads into #350 was scuffed with black marks and both sides of the frame was scraped down to the metal.

- Bedroom 355 – The wall across from the foot of the bed was scuffed with black marks, scraped and gouged and worn down to the drywall in areas.

The left bathroom door frame was scraped down to the metal. The corner to the left was scuffed with black marks, gouged, and the metal strapping was exposed.

- Bedroom 365 – The ceiling finish was cracked along a line, from the mid-section of the bed to the right corner above the dresser. The paint was peeling in areas around the crack. The paint in the right corner, down the side of the wall to the dresser, was raised and was cracked in an area above the dresser. The resident told the inspector that there had been a leak in his/her room, a couple of times, and that he/she believed that it had not happened for approximately six months. He/she believed the leaks had been a result

of an overflowing toilet in the bedroom above his/hers.

Inspector spoke with a maintenance worker, #S104, in the hallway outside of #365. He informed that this damage had occurred several months ago, as a result of a problem with the toilet in the room above, on the 4th floor. He believed that there was a maintenance ticket in place for the remediation of this damage.

Sydenham 3 unit:

- Bedroom 301 – The lower inner bathroom door was extensively scuffed with black marks and scraped and the lower left frame was scraped down to the metal. The outer lower bathroom door was scuffed with black marks, the right frame was scraped down to metal. The metal strapping was exposed along the corner to the right of the bathroom door.

- Bedroom 304 – In the shared bathroom, the caulking around the front of the sink was missing and the base of the front edge was rusty. The area around the drain was cracked and rusty and there was a rust spot under the over flow.

- Bedroom 307 – The metal strapping was exposed along the corner of the lower wall to the left of the bathroom door and the lower left door frame was scraped down to metal.

- Bedroom 308 – The lower wall to the right of the bathroom door was extensively scraped and gouged and the metal corner strapping was exposed. The crumbled pieces of drywall were accumulated between the loose baseboard and bottom of the wall.

- Resident bathroom across from the S33 dining room – The lower walls were scuffed with black marks, scraped and gouged throughout. The metal strapping was exposed on the lower corner of the wall to the left of the garbage receptacle.

There were large brown stains on two ceiling tiles above the toilet.

- Bedroom 313 – The baseboard to the right of the bathroom door was only adhered to the wall in the corner at the bedroom door and it was resting loosely on the floor in an upright position. There was an 11 inch by 25 inch patch above the baseboard where the painted wall surface was torn away with one loose edge in place.

- Bedroom 315 – The metal strapping was exposed along the corner of the wall to the left

of the bathroom door and the wall around this was worn down to the drywall and the lower bathroom door was scuffed with black marks.

The metal strapping on the corner of the wall to the left of the closet was exposed along an 8 inch length.

- Bedroom 317 – The floor was very deeply gouged in a concentrated area front of the bed side table, with accumulation of dark matter within the angular gouged grooves. The floor surface in that area was ridged due to the deep grooves.

In the shared bathroom, the sink was in very poor repair. There was accumulation of rust around the back of the faucet, all around the drain, around the back of the cold water handle. The porcelain was worn from the back of the hot water handle along the left side, and along the right side.

- Bedroom 318 – In the shared bathroom, the sink was in very poor repair. There was accumulation of rust all around the drain, at the back of the tap, in between the drain and the overflow. There were six areas around the top of the basin where the porcelain was worn away. There was a large rust spot on the floor under the sink.

- Bedroom 368 – The sink in the shared bathroom was in poor repair. The porcelain around the drain, between the drain and the over flow, behind the tap, and on the front of the basin was worn away. There were rust spots on the floor under the sink.

- Bedroom 380 – The corner wall to the left of the closet was gouged and the metal strapping was exposed on both sides. The baseboard on the left side of the corner was torn and not adhered. The wall to the left of the bathroom door was scuffed with black marks, gouged and a portion of the metal strapping on the corner was exposed.

The floor in front of the bedside table was extensively gouged, with accumulation of dark matter within the gouges.

Montreal 4 unit:

- Bedroom 425 – The sink in the shared bathroom was in extremely poor repair. The basin was very rusty all around the drain, between the drain and the over flow, on the left side of the outer edge of the basin around to the back left side of the outer basin and on the back right side of the outer basin.

- Bedroom 427 – The metal strapping was exposed along the corner of the wall to the left of the closet.

- Bedroom 433 - The sink was in poor repair in that there was accumulation of rust around the front of the drain and there was a hole in the basin, between the drain and the overflow, which a pen tip could fit into.

- Bedroom 443 - The metal strapping was exposed along the corner of the wall to the left of the closet.

- Bedroom 452 - Resident #002 informed the inspector that he/she was not able to open his/her closet doors. The Inspector attempted to slide open the front door (on right side), and had to lift the door up in order to slide it over to the left. The resident noted that he/she does not have the strength to lift the door up before sliding it. The resident noted that as a result, he/she can not always get access to his/her clothing and belongings in the right side of the closet, which he/she finds very difficult. The resident also pointed out that there was a crack in his/her ceiling, to the side of the bed, that was almost the full length of the room. The resident indicated this crack had been there for approximately a year.

- Bedroom 427 - The metal strapping on the lower corner of the wall to the left of the closet was exposed along a length of 16 inches. The metal strapping on the lower corner of the wall to the left of the bathroom door was exposed along a length of 8 inches.

- Montreal 4 dining room - Above table #1, there was a large brown stain on the ceiling tile.

- Resident bathroom at the M4 nurses station - The ceiling tile above the toilet was missing, exposing the ductwork and pipes above.

- Bedroom 465 - The bottom of the outer bathroom door was scuffed with black marks along a thick line. The left side lower door frame was scraped down to the metal. The edge of the metal strapping was exposed on the lower corner of the wall to the left of the bathroom.

- M4 Tub room, across from 461. There were two ceiling tiles above the tub with large brown stains and there were some dried streaks on the wall below the tiles. In the corner

to the left of the tub the paint was slightly raised and there were dried brown streaks.

The paint above the right side of the tub was peeling, in four areas, along the side of the wall. The lower corner to the right of the tub, and the entire wall space under the sink, had been patched but not painted and some of the patched area was cracking. There was no baseboard in this area. The metal corner strapping on the lower wall to the right of the toilet was exposed. The wall across from the tub was deeply gouged along one straight line and above that the wall surface was peeled, also in one straight line.

The Facility Manager accompanied the Inspector into the tub room and noted that it appeared that there had been a leak from the M5 tub room, directly above this M4 tub room, resulting in the stained ceiling tiles and dried brown streaks on the wall above the tub.

Sydenham 4 unit:

- S4 Tub room, across from 409 – There were brown stains on three ceiling tiles above the tub, and brown/orange marks on the lens of the light fixture above the tub. It was noted that this tub room is directly below the tub room on the S5 unit, across from bedroom 509, where damage to the flooring outside of the shower had been observed by the Inspector and is noted in this report.

There was a circular hole in the wall to the right of the tub, at the level of the door knob. The outer bathroom door was heavily scraped below the door knob and along the base. The corner of the wall to the right of the bathroom door was worn down to the drywall.

Related to the observed damage to bedroom flooring:

The Facilities Manager (FM) explained that the floors are damaged by furnishings and equipment as they are moved around the room. The normal process for floor refinishing does not clean out the groove lines. Staff must scrub out the gouge lines manually in order to clean out the accumulated dark matter. The FM explained that this would be done when a bedroom is prepared for re-occupancy. It is noted that this issue was first described in Compliance Order #005, served to the licensee on September 16th, 2014 as a result of Resident Quality Inspection #2014_179103_0024.

The widespread examples of poor repair observed by the Inspector, the potential for risk to residents in relation to some of the observed issues, such as non-functional lights and

missing radiator covers, and the licensee's ongoing history of non-compliance with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c), require that a subsequent Compliance Order be issued. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 13th day of July, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2016_346133_0025
Log No. / Registre no:	010213-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 13, 2016
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)

Linked to Existing Order / Lien vers ordre existant: 2015_444602_0034, CO #001;

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 :

In order to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c), 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 will conduct a comprehensive assessment of all resident home areas and bedrooms, with the possible exception of bedrooms already captured by the licensee's new auditing system that began in February 2016. The assessed areas must include resident bedrooms and bathrooms, and all common areas used by residents such as bathing rooms, dining rooms, lounges and activity rooms. The audits must assess the condition of walls, floors, ceilings, all fixtures (i.e. light covers, light functionality, condition of sinks, security of toilets) and furnishings. Bedrooms audited since February 2016 may need to be reassessed if the process did not include all items noted above.

The licensee will then develop and implement a plan that will ensure that the extensive list of examples of poor repair within the grounds, and all maintenance needs identified by the licensee's audit, are corrected. Identified issues that present a potential for risk to residents are to be corrected immediately, such as, but not limited to: non-functional lights are to be repaired/replaced, missing radiator covers are to be replaced, loose toilet seats are to be secured (i.e - bedroom #572)

The licensee must ensure the Facility Manager, or maintenance staff, are alerted without delay to any maintenance issues that may pose a potential risk for residents. If this is to be done verbally, the issue must in some way be formally captured within the maintenance reporting system. The licensee must ensure that all staff are re-educated and re-instructed about the formal process that is to be followed should they become aware of any maintenance issues that may pose a potential risk for residents. This re-education and re-instruction is to be documented.

The licensee will ensure the continuation of a routine auditing system for the bedrooms and home areas, to ensure unreported issues are identified, and to allow for an ongoing assessment of the overall efficacy of the maintenance program.

The licensee will ensure that the maintenance program is organized and resourced to allow for the ongoing routine, preventative and remedial maintenance needs of the home, in a timely manner, in addition to the focus on addressing this compliance order.

Grounds / Motifs :

1. 1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c) in that the licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has a history of non-compliance with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c). On September 16, 2014, as a result of Resident Quality Inspection (RQI) #2014_179103_0024, the licensee was served with Compliance Order (CO) #005, with a compliance date of March 16th, 2015. As a result of follow up to CO #005, over the course of the following RQI, #2015_444602_0034, the CO (#005) was closed and linked to a subsequent CO (#001), as it could not be complied. The licensee was served with CO #001 on December 21, 2015 by Inspector #197. The original compliance date for CO #001 was April 30th, 2016. On April 29th, 2016, the compliance date for CO#001 was extended to June 3rd, 2016, by Inspector #133, upon request from the licensee.

In addition, Inspector #133 conducted an "Other" inspection at the home on March 7-9, 2016 (#2016_346133_0012). Over the course of the inspection, 37

examples of one or more non-functional lights in identified areas were noted. The licensee was issued a Written Notification as a result, pursuant to LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c). The finding of non-compliance was issued as additional evidence in support of CO #001.

CO #001 directed the licensee as follows:

"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 develop, implement and maintain a scheduled preventative maintenance and repair program that includes a regular audit of the home to identify areas that are in need of repair and to ensure that required maintenance, repairs and service issues are corrected promptly. The licensee will ensure written schedules and procedures are in place for remedial maintenance as per O. Reg. 79/10, s. 30 (1) 1".

On June 7th, 2016, Inspector #133 met with the Facilities Manager (FM). The FM explained that due to financial constraints, the decision was made to focus maintenance resources exclusively on addressing the examples of disrepair that were noted by Inspector # 197 in the grounds that supported CO #001, as opposed to trying to fix everything. As well, all examples of non-functional lights, as per inspection #2016_346133_0012, had been addressed. The FM elaborated that a full audit of the home had been conducted after that inspection, focused on the functionality of lights, and that all identified deficiencies had been corrected.

Relating to the requirement within CO #001 for the licensee to establish a "regular audit of the home to identify areas that are in need of repair and to ensure that required maintenance, repairs and service issues are corrected promptly", the FM explained that an annual audit process for the home had been developed. The FM explained that over the year, the audit process would reveal the additional remedial maintenance needs of the home. On June 9th, 2016, the FM informed that the audit process for resident bedrooms started in February 2016. To date, 86 of the 243 bedrooms had been audited. The bedroom audits had led to the creation on 78 new maintenance tickets. The FM informed that none of the 78 new maintenance tickets had been actioned, to date. The audit process for common areas on the care units was to have begun at the beginning of June 2016. The FM explained that when a plan was developed to address the maintenance issues identified by the audits, the first ticket that was created,

in February 2016, would be the first ticket to be addressed.

As such, there were no schedules in place for remedial maintenance and the maintenance program was not organized to ensure that all required maintenance, repairs and service issues are corrected promptly.

On June 13th, 2016, following the conclusion of the onsite Follow Up inspection, the FM called the Inspector and informed that beginning at the end of June 2016, the two maintenance workers would be dedicated to the remedial maintenance needs of the home, two days per week. The FM indicated that this had been planned prior to the Follow Up inspection, yet he had forgotten to inform the Inspector during the onsite inspection.

Over the course of the Follow Up inspection, June 6th – 9th, 2016, Inspector #133 confirmed that all of the examples of disrepair that were noted by Inspector # 197 in the finding of non-compliance that supported CO #001 had been addressed. As well, it was verified that all examples of non-functional lights, as per inspection #2016_346133_0012, had been addressed.

Over the course of the inspection, Inspector #133 noted widespread examples of poor repair throughout the home, the majority of which was in areas that had not been referenced in CO #001.

Related to bedroom lights:

Over the course of the inspection it was noted that the cover (the lens) for the square, flush mounted, ceiling light fixture within the immediate entrance area of forty four observed resident bedrooms was missing. The bedrooms in issue are as follows: 576, 572, 570, 514, 516, 517,519, 522, 524, 531, 534,536,538, 543, 547, 549, 551, 552, 553, 560, 565, 562, 330, 341, 343, 350, 348, 301,302, 366, 376, 443,449, 452, 416, 432, 458, 465, 467,469,474,476,477 and 483. In five bedrooms, identified below, a non-functional light was observed.

The ceiling light fixtures are designed to have a cover (lens). On June 8th, 2016, resident #002, in bedroom #452, told the Inspector that he/she found there was a glare from the light due to the missing cover. The FM acknowledged the missing covers, and explained to the Inspector that they can no longer find replacement covers, so they have to have them made, or change the fixture. The FM indicated that, as this was not a safety issue, maintenance resources

were not being allocated. On June 9th, 2016, the Inspector had observed, in bedrooms M-435 and M-448, that there was a clear textured cover on the entrance light fixtures, held in place with clear tape on the outer perimeter of the fixture. In all previous cases, where there was a cover observed, it was smooth and opaque, and fit into the inner perimeter of the fixture to cover the fluorescent bulb. The FM was unsure if the home had cut and affixed these two unique covers, and indicated the Inspector would have to check with the maintenance workers. The Inspector spoke with the two maintenance workers who are tasked with remedial maintenance duties, and neither could recall having creating these covers.

In bedroom S - 520, on June 7th, 2016, it was observed that the lower light in the over bed fixture was not functional.

In bedroom M-550, on June 7th, 2016, it was observed that the ceiling mounted light within the entrance of the room was not functional.

In bedroom M-328, on June 8th, 2016, it was observed that the lower light in the over bed fixture was not functional.

In bedroom S-417, on June 9th, 2016, it was observed that the upper light in the over bed fixture was not functional.

In bedroom M-458, on June 9th, 2016, it was observed that the light switch for the top light in the over bed light fixture was missing and therefore the top light could not be turned on.

Related to baseboard radiators:

Over the course of the inspection, it was noted that a length of radiator cover, ranging from one and a half inches to three and a half inches, was missing from ten observed areas. As a result, the sharp metal radiator fins were exposed, in a central area of the radiator. The areas in issues are as follows: S5 welcome room, S - 513, M5 dining room, M3 dining room, M- 327, M-337, M – 339, S – 313, S – 317 and M – 431.

Related to shelves above toilets:

Over the course of the inspection, it was noted that the shelving was in very poor

repair in sixteen observed resident bathrooms. The laminate surface was worn or broken away along the length of the front edge of the shelves, up to one and a half inches in width, and in some cases also along the back edge and also within the central area. The absorbent particle board subsurface was exposed and swollen and, in some cases, crumbling. Such surfaces cannot be cleaned or disinfected, and they are located directly above the toilets. The shared bathrooms in issue are as follows: M-523/524, M-529/531, M-533/535, M-537/539, M-555/557, M-558/559, M-324/323, M-331/329, M-325/327, M-329/331, M-333/335, S-302/304, S-306/308, S-317/319, S-318/320 and M-433/435.

Related to bedroom S-514:

As observed on June 7th, 2016, the toilet seat and the raised arms attached to the seat were not securely affixed to the toilet bowl and moved freely from side to side. The top and sides of the left arm rest were broken and there were sharp plastic edges around the perimeter. The two exposed screws that held the plastic onto the metal frame were raised.

On June 7th, 2016, A Personal Support Worker, PSW #S101, told the Inspector that the toilet had been in such a condition since March 2016. The PSW indicated that the issue had been reported. PSW #S101 told the Inspector that resident #001 was taken to a nearby common bathroom to be toileted, due to the potential risk.

On June 8th, 2016, the Facilities Manager (FM) informed that the condition of the resident #001's toilet had been reported via the maintenance reporting system on May 5th, 2016. The FM explained that the maintenance workers had been focused on addressing the issues identified in CO #001, and that the ticket related to #514 had not yet been actioned. The seat was securely affixed to the bowl, and the damaged arms were removed, on June 8th, 2016.

Related to bedroom S-520:

As observed on June 7th, 2016, behind the resident's bed, the wood panel in place to protect the wall from damage had detached from the metal strip that had held it in place. The right side of the panel was being held up by the strip as it was stuck in it and the left side bottom corner was resting on the floor. The metal strip was not flush with the wall and the left side of it was raised upwards.

The corner edge of the left side of the strip was sharp, and it was close behind the very top of the headboard.

At the inspector's request, the Registered Nurse (RN) on the unit, #S102, accompanied the Inspector into the bedroom. The RN indicated that she had not been aware of the problem, and agreed that it was a potential safety risk. The RN and the Inspector lifted the panel off the metal strip and rested it, upright, on the floor behind the bed. The RN brought in a towel and tucked it all around the left corner edge of the metal strip. The RN indicated she would report the issue immediately.

On June 8th, 2016, the FM confirmed that RN #S102 had reported the safety issue, via the maintenance reporting system, the previous day. The FM directed maintenance staff to re-affix the wood panel behind the bed on June 8th, 2016.

2. The following additional examples of observed poor repair, in resident bedrooms, bathrooms, and common areas, predominantly detail the condition of walls, floors and sinks. It is to be noted that the Inspector observed the majority of bedrooms and common areas on the 5th and 3rd floors. Observations on the 4th floor were generally exclusive to areas noted in CO#001 and some common areas. Some additional 4th floor bedrooms were partially observed, mainly from the hallway, if the door was open as the inspector passed by.

Sydenham 5 unit:

- Tub and shower room across from bedroom #508 - The corner of the wall between the shower stall and the door leading into the toilet room was damaged in two distinct areas, whereby the paint and drywall had broken away and the metal strapping beneath was exposed. The lower area was approximately 9.5 inches in length and 2.5 inches in width in the widest section. The top area was approximately 8.5 inches in length and 4.5 inches in width in the widest section.

The floor seam along the shower stall sill was not intact (48 inch length) and at the corner closest to the shower faucet, the flooring was slightly raised as it was not adhered to the sub surface. In that corner, a section of flooring measuring approximately 6.5 inches by 1.5 inches was missing.

The wall next to the tub, around the electrical outlet for the fan and the lift

charger, was extensively gouged.

In the bathroom, the wall underneath the soap dispenser was worn down to the drywall, along the top of the sink counter, and the paint above it was chipping and peeling.

There was a ceiling tile above the sink that had a brown semi-circle stain on it.

- S5 Dining room, side opposite nurses' station - At table #2, on the lower wall to the right, there was a circular area where the paint had been peeled away, measuring approximately 4 inches by 2.5 inches. At table #2, on the lower wall to the left, there was an area where the paint was peeling and the drywall was gouged.

Within the servery, there were two ceiling tiles that had brown circular stains on them, one above the fridge and the other closer to the hand sink.

- S5 Dining room, side opposite the elevator - The lower wall between the first and second tables along the wall that faces the hallway was in very poor repair. The lower portion of the column between the tables was extensively worn and the metal strapping on the left front side was exposed, area of approximately 7.5 inches by 3 inches. The lower wall, between the column and the second tables, was worn down to drywall in a patch approximately 21 inches in length and 3 inches in width, with a smaller worn area closer to the second table. There was a 12 inch by 2 inch area in the lower wall, upon entry to the room, where the drywall was crumbling and broken into small chunks.

- Bedroom 505 - The floor, in front of the bed side table, was gouged. The floor, at the foot of the bed was more extensively gouged. There was accumulation of dark matter within the gouge lines. An 8.5 inch length of floor seam, at the side of the bed, was not intact.

- Bedroom 507 - The lower wall across from the bed was in poor repair in that along a 30 inch length the paint was peeling and chipping away, with some areas within that were worn down to the drywall.

- Bedroom 583 – The upper wall was deeply gouged in small areas all around the lower portion of the hand sanitizer dispenser. The lower wall, to the right of the inner bedroom door frame was in poor repair in that there was horizontal

strip where the paint had peeled and the wall was gouged.

The floor, in front of the bed side table, was extensively gouged. There was accumulation of dark matter within the gouge lines.

- Bedroom 581 – The lower wall across from the foot of the bed was in poor repair whereby there was a 14 inch horizontal length along which the paint had peeled and some areas were worn down to the drywall.

The floor, between the foot of the bed and the wall, was gouged. There was accumulation of dark matter within the gouge lines.

- Bedroom 577 – The floor in front of the rolling over bed table and the high backed comfortable easy chair was gouged. The floor between the foot of the bed and the table across from the bed was extensively gouged. There was accumulation of dark matter within the gouge lines.

- Bedroom 575 – The floor, in front of the bed side table, was extensively gouged, with accumulation of black matter within the gouge lines.

- Bedroom 572 – The toilet seat was loose; it could be moved freely from side to side.

- Bedroom 567 – The lower wall next to the toilet was in poor repair in that the paint was cracked, peeled down to the drywall and the area above the baseboard was damp, with one small blackened area.

- Bedroom 570 - The lower wall to the right of the bathroom door was in poor repair in that the area was scraped, gouged and the corner metal strapping was exposed. The lower wall across from the bed was in poor repair in that there was a 29 inch horizontal length along which the paint was cracked or worn down to the drywall.

The floor, at the foot of the bed, was gouged, with accumulation of black matter within the gouge lines.

- Bedroom 571 – The wall across from the bed was extensively gouged, scraped and peeling. To the left of the closet, the corner metal strapping was exposed on both sides.

- Resident bathroom across from the S5 dining room – The wall next to the toilet was gouged and pitted.

- S5 tub room, across from #522 – The lower wall upon entry, to the right of the tub, was gouged along a 5 inch length and the paint was scraped and peeling below the gouged area. The metal strapping was exposed along both sides of the wall at the sink (11 and 19 inches in length, 1 inch to 1.5 inches in width).The edge of the metal strapping was exposed along the lower corner of the wall next to the tub.

- Bedroom 513 – The lower wall immediately above the baseboard, to the right of the bathroom door, was in poor repair as there was a 4 inch length of drywall that was gouged and crumbled, and the metal strapping was exposed.

- Bedroom 514 – The lower outer bathroom door was in poor repair as it was extensively scraped and scuffed with black marks throughout as was the lower outer door frame, and lower wall, to the left of the bathroom door. The wall across from the foot of the bed was extensively scuffed with black marks and scraped and areas were worn down to the drywall. The lower inner bathroom door was extensively scuffed with black marks and the door frame was scraped down to the metal in areas.

- Bedroom 517 - The floor was pitted and gouged in an area at the head of the bed, with accumulation of dark matter within the gouges. The floor was cracked apart in two other areas. The larger cracked area was approximately 23 inches by 10 inches and the smaller cracked area was approximately 11 inches by 9 inches.

- Bedroom 518 – The lower wall across from the bed was scuffed with black marks, scraped and it was worn down to the drywall in three distinct circular areas.

In the shared bathroom, there was no cover for the toilet tank. The lower door, leading into #518, and the lower wall to the right of the door, was scuffed with black marks. There was an area, just above the baseboard, to the right of the door leading into #518, where the paint was peeled and cracked and there was an accumulation of black matter. The lower door, leading into #520 was extensively scuffed with black marks and the door frame was scraped down to

the metal.

The floor, in front of the bed side table, was pitted. The floor, in front of the corner table was gouged. There with accumulation of dark matter within the gouges and pits.

- Bedroom 520 – The lower outer right bathroom door frame was scraped down to the metal in areas, the lower outer bathroom door was scuffed with black marks and the lower corner of the wall to the left of the bathroom door was damaged and the metal strapping was exposed.

Montreal 5 unit:

- Bedroom 523 – The baseboard behind the bed was not adhered to the wall and was resting on the floor. There was no baseboard on the wall to the left of the bathroom door. In the bathroom, shared with #524, there was no baseboard on the wall behind the toilet and there was no baseboard on the wall under the sink.

- Bedroom 526 – The floor in front of the bedside table was extensively gouged, with accumulation of dark matter within the gouge lines.

- M5 tub room, across from bedroom 532 – The lower wall, to the right of the tub, was scraped, peeling and gouged in areas with a circular hole above the door stop, with chunks of crumbled drywall within it. The corners of the wall at the sink were in very poor repair, the drywall was broken off and the metal strapping was exposed, in lengths of approximately 47 inches on both sides.

The corner metal strapping was exposed along the corner of the wall under the sink.

Montreal 5 nurses station – One ceiling tile next to light fixture was stained pink and orange in a semi-circular area.

- Bedroom 546 – There was a hole in the ceiling next to the access panel, above the head of the bed. The outer perimeter of the hole was discolored and the paint around the perimeter of the hole was peeling.

- Bedroom 550 - The lower wall across from the foot of the bed was scuffed with

black marks and the paint worn down to drywall in areas

- Bedroom 554 – The lower wall across from bed #1 was scuffed with black marks, scraped and worn down to drywall within areas. The lower corner of the wall to the right of the area described above was worn down and the metal strapping was exposed.

- Bedroom 558 - The floor in front of the dresser was gouged at the floor in front of the bedside table was extensively gouged, with accumulation of black matter within the gouge lines.

Montreal 3 unit:

- Bedroom 331 – The lower corner metal strapping was exposed, on the wall to the left of the closet. The lower corner metal strapping was exposed, on the wall to the left of the bathroom door.

- Resident bathroom in the area of the M3 nurses station – There was a ceiling tile with a brown circular stain above the toilet.

The lower wall to the right of the toilet was in poor repair in that a patch of drywall had broken off and the corner metal strapping was exposed and the paint around the area was peeling. (6.5 inches by 1 ¼ inches)

- M3 tub room, across from bedroom 361 – The toilet paper holder was missing from the wall next to the toilet and there was a bucket with rolls of toilet paper in it.

- Bedroom 325 – The lower right bathroom door frame was scraped down to the metal and drywall on the lower corner of the wall to the right of the bathroom door was broken off to expose the metal strapping (area was 8 inches long and 5.5 inches wide in the widest section).

- Bedroom 327 – There was a hole in the wall under the window, approximately 4 inches by 6 inches.

- Bedroom 328 – The outer lower bathroom door was scuffed with black marks. The wall to the left was scuffed with black marks, scraped and gouged. The lower left corner was broken down to the metal strapping. The corner to the right

of the bathroom door, next to the bed side table, was broken to expose a 19 inch length of metal strapping.

- Bedroom 332 – The metal strapping was exposed along the corner of the wall to the right of the bathroom door. The lower outer bathroom door was scuffed with black marks, scraped and gouged and the door frames were scraped down to the metal on both sides.

- Bedroom 337 – The right bathroom door frame was scraped down to the metal and the edge of the metal strapping was exposed along the corner to the right of the bathroom door.

In the shared bathroom, the inner door that leads into 337 was extensively scuffed with black marks and the frame on both sides was scraped down to the metal. The inner door that leads into 339 was in a similar condition, but to a lesser degree.

- M3 staff bathroom – The wall under the soap dispenser was in very poor repair. There was extensive moisture damage. The outer wall surface has worn away and there was an area of brown hard porous matter, with accumulation of white matter around the area. This bathroom was observed upon request from nursing staff. A Personal Support Worker, #S103, informed that a maintenance ticket had been completed for this issue for the first time approximately one to two years ago and most recently, six months ago.

- Bedroom 352 – In the shared bathroom, the inner door that leads into #350 was scuffed with black marks and both sides of the frame was scraped down to the metal.

- Bedroom 355 – The wall across from the foot of the bed was scuffed with black marks, scraped and gouged and worn down to the drywall in areas.

The left bathroom door frame was scraped down to the metal. The corner to the left was scuffed with black marks, gouged, and the metal strapping was exposed.

- Bedroom 365 – The ceiling finish was cracked along a line, from the mid-section of the bed to the right corner above the dresser. The paint was peeling in areas around the crack. The paint in the right corner, down the side of the wall to

the dresser, was raised and was cracked in an area above the dresser. The resident told the inspector that there had been a leak in his/her room, a couple of times, and that he/she believed that it had not happened for approximately six months. He/she believed the leaks had been a result of an overflowing toilet in the bedroom above his/hers.

Inspector spoke with a maintenance worker, #S104, in the hallway outside of #365. He informed that this damage had occurred several months ago, as a result of a problem with the toilet in the room above, on the 4th floor. He believed that there was a maintenance ticket in place for the remediation of this damage.

Sydenham 3 unit:

- Bedroom 301 – The lower inner bathroom door was extensively scuffed with black marks and scraped and the lower left frame was scraped down to the metal. The outer lower bathroom door was scuffed with black marks, the right frame was scraped down to metal. The metal strapping was exposed along the corner to the right of the bathroom door.

- Bedroom 304 – In the shared bathroom, the caulking around the front of the sink was missing and the base of the front edge was rusty. The area around the drain was cracked and rusty and there was a rust spot under the over flow.

- Bedroom 307 – The metal strapping was exposed along the corner of the lower wall to the left of the bathroom door and the lower left door frame was scraped down to metal.

- Bedroom 308 – The lower wall to the right of the bathroom door was extensively scraped and gouged and the metal corner strapping was exposed. The crumbled pieces of drywall were accumulated between the loose baseboard and bottom of the wall.

- Resident bathroom across from the S33 dining room – The lower walls were scuffed with black marks, scraped and gouged throughout. The metal strapping was exposed on the lower corner of the wall to the left of the garbage receptacle.

There were large brown stains on two ceiling tiles above the toilet.

- Bedroom 313 – The baseboard to the right of the bathroom door was only adhered to the wall in the corner at the bedroom door and it was resting loosely on the floor in an upright position. There was an 11 inch by 25 inch patch above the baseboard where the painted wall surface was torn away with one loose edge in place.

- Bedroom 315 – The metal strapping was exposed along the corner of the wall to the left of the bathroom door and the wall around this was worn down to the drywall and the lower bathroom door was scuffed with black marks.

The metal strapping on the corner of the wall to the left of the closet was exposed along an 8 inch length.

- Bedroom 317 – The floor was very deeply gouged in a concentrated area front of the bed side table, with accumulation of dark matter within the angular gouged grooves. The floor surface in that area was ridged due to the deep grooves.

In the shared bathroom, the sink was in very poor repair. There was accumulation of rust around the back of the faucet, all around the drain, around the back of the cold water handle. The porcelain was worn from the back of the hot water handle along the left side, and along the right side.

- Bedroom 318 – In the shared bathroom, the sink was in very poor repair. There was accumulation of rust all around the drain, at the back of the tap, in between the drain and the overflow. There were six areas around the top of the basin where the porcelain was worn away. There was a large rust spot on the floor under the sink.

- Bedroom 368 – The sink in the shared bathroom was in poor repair. The porcelain around the drain, between the drain and the over flow, behind the tap, and on the front of the basin was worn away. There were rust spots on the floor under the sink.

- Bedroom 380 – The corner wall to the left of the closet was gouged and the metal strapping was exposed on both sides. The baseboard on the left side of the corner was torn and not adhered. The wall to the left of the bathroom door was scuffed with black marks, gouged and a portion of the metal strapping on the corner was exposed.

The floor in front of the bedside table was extensively gouged, with accumulation of dark matter within the gouges.

Montreal 4 unit:

- Bedroom 425 – The sink in the shared bathroom was in extremely poor repair. The basin was very rusty all around the drain, between the drain and the over flow, on the left side of the outer edge of the basin around to the back left side of the outer basin and on the back right side of the outer basin.

- Bedroom 427 – The metal strapping was exposed along the corner of the wall to the left of the closet.

- Bedroom 433 - The sink was in poor repair in that there was accumulation of rust around the front of the drain and there was a hole in the basin, between the drain and the overflow, which a pen tip could fit into.

- Bedroom 443 - The metal strapping was exposed along the corner of the wall to the left of the closet.

- Bedroom 452 - Resident #002 informed the inspector that he/she was not able to open his/her closet doors. The Inspector attempted to slide open the front door (on right side), and had to lift the door up in order to slide it over to the left. The resident noted that he/she does not have the strength to lift the door up before sliding it. The resident noted that as a result, he/she can not always get access to his/her clothing and belongings in the right side of the closet, which he/she finds very difficult. The resident also pointed out that there was a crack in his/her ceiling, to the side of the bed, that was almost the full length of the room. The resident indicated this crack had been there for approximately a year.

- Bedroom 427 - The metal strapping on the lower corner of the wall to the left of the closet was exposed along a length of 16 inches. The metal strapping on the lower corner of the wall to the left of the bathroom door was exposed along a length of 8 inches.

- Montreal 4 dining room - Above table #1, there was a large brown stain on the ceiling tile.

- Resident bathroom at the M4 nurses station - The ceiling tile above the toilet was missing, exposing the ductwork and pipes above.

- Bedroom 465 - The bottom of the outer bathroom door was scuffed with black marks along a thick line. The left side lower door frame was scraped down to the metal. The edge of the metal strapping was exposed on the lower corner of the wall to the left of the bathroom.

- M4 Tub room, across from 461. There were two ceiling tiles above the tub with large brown stains and there were some dried streaks on the wall below the tiles. In the corner to the left of the tub the paint was slightly raised and there were dried brown streaks.

The paint above the right side of the tub was peeling, in four areas, along the side of the wall. The lower corner to the right of the tub, and the entire wall space under the sink, had been patched but not painted and some of the patched area was cracking. There was no baseboard in this area. The metal corner strapping on the lower wall to the right of the toilet was exposed. The wall across from the tub was deeply gouged along one straight line and above that the wall surface was peeled, also in one straight line.

The Facility Manager accompanied the Inspector into the tub room and noted that it appeared that there had been a leak from the M5 tub room, directly above this M4 tub room, resulting in the stained ceiling tiles and dried brown streaks on the wall above the tub.

Sydenham 4 unit:

- S4 Tub room, across from 409 – There were brown stains on three ceiling tiles above the tub, and brown/orange marks on the lens of the light fixture above the tub. It was noted that this tub room is directly below the tub room on the S5 unit, across from bedroom 509, where damage to the flooring outside of the shower had been observed by the Inspector and is noted in this report.

There was a circular hole in the wall to the right of the tub, at the level of the door knob. The outer bathroom door was heavily scraped below the door knob and along the base. The corner of the wall to the right of the bathroom door was worn down to the drywall.

Related to the observed damage to bedroom flooring:

The Facilities Manager (FM) explained that the floors are damaged by furnishings and equipment as they are moved around the room. The normal process for floor refinishing does not clean out the groove lines. Staff must scrub out the gouge lines manually in order to clean out the accumulated dark matter. The FM explained that this would be done when a bedroom is prepared for re-occupancy. It is noted that this issue was first described in Compliance Order #005, served to the licensee on September 16th, 2014 as a result of Resident Quality Inspection #2014_179103_0024.

The widespread examples of poor repair observed by the Inspector, the potential for risk to residents in relation to some of the observed issues, such as non-functional lights and missing radiator covers, and the licensee's ongoing history of non-compliance with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c), require that a subsequent Compliance Order be issued. [s. 15. (2) (c)] (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 13th day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE

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