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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 3, 2017	2016_360111_0032	033077-16	Complaint

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

SPRINGDALE COUNTRY MANOR
2698 CLIFFORD LINE R. R. #5 PETERBOROUGH ON K9J 6X6

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

LYNDA BROWN (111), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 22, 2016

A compliant inspection was completed related to low lighting.

During the course of the inspection, the inspector(s) spoke with the Administrator, Maintenance, and residents. Lighting levels were measured in all corridors, dining rooms, lounges, resident rooms, resident bathrooms, tub/shower rooms, and resident common area washrooms.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

The licensee failed to ensure that required levels of lighting were provided in all areas of the long term care home including: a minimum of 215.28 lux of continuous consistent lighting throughout corridors, in residents' rooms, en suite washrooms, common area washrooms; A minimum level of 375.73 lux at the bed of each resident when the bed is at the reading position (head of the bed).

On a specified date, illumination levels in corridors, resident rooms and resident bathrooms were checked by Inspector #111 & #531. A hand held Amprobe LM-120 light meter was use. The meter was held 3 to 4 feet above the floor surface with all available window coverings and doors closed. All available electric light fixtures were turned on

and warmed up.

During the RQI in 2015 & 2016, the inspectors noted low lighting levels in corridors and resident rooms. During the RQI in 2015, a former specified resident complained the lighting level in the room and washroom was "terrible". The former resident also indicated having difficulty performing activities of daily living even despite bringing in additional light fixtures and a magnifying mirror. The resident had also requested the lighting levels in the home be “looked into".

During this inspection, resident #001 complained to Inspector #531 that the lighting in the room “is dark” and that one of the over bed wall mounted lights “does not have a proper pull cord”. Resident #001 stated “it is darker in the room in the evening and at night”. The resident indicated that the resident has compromised sight and stated “the lighting at night is so dark it makes it difficult to get up to the bathroom”.

The scope was widespread as the low lighting levels were identified throughout the home’s corridors, resident rooms and resident en suite bathrooms. The severity is high risk as low levels of lighting are a potential risk to the health, comfort and well- being of residents. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments; to conduct assessments: to provide treatments. Low levels of illumination and shadows may negatively impact resident’s perception of the surrounding environment affecting mobility, nutritional intake, and overall quality of life.

Levels of illumination in corridors throughout the home (except the large main entrance area which contained lounges and a dining room) were measured at 50 -75 % of the required lighting levels of 215.28 lux.

Levels of illumination in all resident en suite bathrooms throughout the home (except from rooms 34 to 51) were measured at 40-50% of the required lighting levels of 215.28 lux.

Levels of illumination in all resident rooms throughout the home were measures at 50-75% of the required lighting levels of 215.28 lux.

In resident rooms 34 to 51, there were wall-mounted, swing-arm light fixtures with a shade that was located above the side tables (to the right of the head of the beds).

Levels of illuminations in these rooms were measured at 20-30% of the required lighting levels of 375.73 lux at the head of the bed of each resident, when the bed is at the reading position (head of the bed). Most of the swing arms were difficult to swing over the head of the bed) or did not swing at all which prevents the resident from being able to have a reading light at the head of the bed.

Levels of illumination in the resident common bathroom (off the dining room) measured between 25 -50% of the required lighting levels of 215.28 lux.

In addition, over half of the resident rooms were noted to be missing the pull cords from the over bed, wall-mounted light fixtures. Not having a pull cord for these light fixtures does not allow the residents the ability to turn the lights on or off. [s. 18.]

Additional Required Actions:

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

Issued on this 3rd day of January, 2017

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) :	LYNDA BROWN (111), SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2016_360111_0032
Log No. / Registre no:	033077-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 3, 2017
Licensee / Titulaire de permis :	Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	SPRINGDALE COUNTRY MANOR 2698 CLIFFORD LINE, R. R. #5, PETERBOROUGH, ON, K9J-6X6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MAUREEN KING

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

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, 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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
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O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

1. The licensee will ensure a minimum of 375.73 lux at the head of the bed of each resident, when the bed is at the reading position (head of the bed) for rooms 34 to 51.
2. That all wall-mounted, swing arm light fixtures in resident rooms 34 to 51 are in proper working order and there are pull-cords in place for all wall-mounted, above bed light fixtures.
3. A process is in place for staff to monitor and report to maintenance when the wall-mounted, above resident beds pull-cords are not available or when the wall-mounted, swing arm light fixtures are not operational.
4.A plan is developed to promptly address all other resident care areas of the long-term care home where lighting levels do not meet the minimum of 215.28 lux.

The licensee will provide a written progress report indicating the status of the lighting levels every month from the date the order is served until the work is completed. This progress report must be submitted in writing to the MOHLTC, Attention: Lynda Brown, Fax (613)569-9670.

Grounds / Motifs :

1. The licensee failed to ensure that required levels of lighting were provided in all areas of the long term care home including: a minimum of 215.28 lux of continuous consistent lighting throughout corridors, in residents' rooms, en suite washrooms, common area washrooms; A minimum level of 375.73 lux at the bed of each resident when the bed is at the reading position (head of the bed).

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lighting in the room "is dark" and that one of the over bed wall mounted lights "does not have a proper pull cord". Resident #001 stated "it is darker in the room in the evening and at night". The resident indicated that the resident has compromised sight and stated "the lighting at night is so dark it makes it difficult to get up to the bathroom".

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Levels of illumination in the resident common bathroom (off the dining room) measured between 25 -50% of the required lighting levels of 215.28 lux.

In addition, over half of the resident rooms were noted to be missing the pull cords from the over bed, wall-mounted light fixtures. Not having a pull cord for these light fixtures does not allow the residents the ability to turn the lights on or off. [s. 18.] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 12, 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 3rd day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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