Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 9, 2014	2014_220111_0006	O-000205-14	Resident Quality Inspection

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South, WHITBY, ON, L1N-9W2

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

STRATHAVEN LIFECARE CENTRE
264 King Street East, Bowmanville, ON, L1C-1P9

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

LYNDA BROWN (111), GWEN COLES (555), KELLY BURNS (554), MEGAN MACPHAIL (551), WENDY BERRY (102)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 17-21 and 24-25, 2014

Three Critical incident inspections were completed concurrently during this inspection (log# 000408, 000447, & 000399)

During the course of the inspection, the inspector(s) spoke with Residents, families, Resident Council President, Administrator, Director of Care (DOC), Director of Resident and Family Services (DRFS), Environmental Services Manager, Dietary Manager, Food Service Supervisor, Receptionist, Social Worker, RAI Coordinator, Registered Nurses(RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides, Housekeepers, Laundry Aides, and Activity Aides.

During the course of the inspection, the inspector(s) observed a dining service, reviewed health records of residents, reviewed the home's investigation reports, Resident council meeting meetings, and reviewed the home's policies (infection control, prevention of abuse, falls prevention, continence care, drug destruction, preventative maintenance, missing laundry, complaints, restraints and medication administration.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

Findings/Faits saillants :

The Licensee failed to ensure that each resident's bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

Privacy curtains were not provided to ensure sufficient privacy in the following rooms which are occupied by more than one resident:
-Room 204 (occupied by two residents), the privacy curtain between both resident's is obstructed by the ceiling lift; there was no privacy curtain in place for the resident in bed #1; the privacy curtain for the resident in bed #2 was short by three feet.
-Room 209 (occupied by two residents), the privacy curtain between both residents is obstructed by the ceiling lift and one resident's curtain is short by two feet.
-Room 2012 (occupied by four residents), is not easily movable along the track; the curtain used to enclose the bed space for Resident #4752 is approximately 2 feet short; the overhead lift does not allow the privacy curtains enclosing bed #2 and #3 to remain closed when the lift is in motion on the track; the resident in bed #2 privacy curtain is obstructed by the ceiling lift track.
-Room 2016 (occupied by three residents), specific to bed #2 is obstructed by the ceiling lift cord and prevents privacy when the ceiling lift is in motion along the track;the privacy curtain for bed #3 is approximately 3 feet short enclosing the bed and at minimum of 1.5 feet short in separating bed #2 and #3. [s. 13.]

2. Resident rooms occupied by more than one resident do not have sufficient privacy curtains to provide privacy when overhead lifts are in motion in rooms 3002, 3003, 3005, 3007, 3009.
Note: this issue was identified and was to be addressed prior to admission of residents to the short stay program (interim) beds on the 3rd floor. [s. 13.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The resident staff communication and response system is not available in the following resident accessible areas:
- lower level hair salon
- lower level physio room
-lower level activity room

The lack of availability of the resident staff communication and response system in areas accessible to residents is a potential risk to the health, safety and well being of residents.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

Light levels were checked during the inspection on March 21 and 24, 2014. A "G.E." model light meter was used. The light meter was held 3 to 4 feet above the floor surface; all available electric lights were turned on in each area being checked. In bedrooms, window coverings were closed; privacy curtains were open, where provided.

Light levels of less than 25 % to 50 % of the required lighting level of 215.28 lux was provided in the majority of residents' bedrooms on the 1st and 2nd floors.

1st and 2nd floor corridor lighting levels were less than 25 % to 50 % over the majority of the length of each corridor. 215.28 lux of continuous, consistent lighting is not provided throughout the corridors.

Lighting in several residents' washrooms and common rooms was identified to be below 50 % of the required illumination level of 215.28 lux: washrooms that adjoin rooms 208, 2000, Lounge adjacent to room 2006, washroom near room 102. This is not an all inclusive list as all areas were not entered and checked with a light meter.

Insufficient levels of illumination are a potential risk to the health, safety, comfort and well being of residents. Residents' visual acuity and perception of surroundings may be compromised. [s. 18.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 :

The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and a good state of repair which is a potential risk to the health, comfort, safety and well being of residents.

The following area were identified:
- walls in the majority of bedrooms were scraped and/or damaged exposing a non-intact surface that can not be effectively cleaned,
-the finish had worn from wooden handrails through out corridors on all floors and wood handrails were also identified to be loose in 2 areas(which were tightened upon notification to the Environmental Services Supervisor),
-the finish was scraped and worn from wood frames on many of the chairs that are provided for resident use,
- the finish has scraped, chipped and/or worn from the lower surfaces of the majority of wardrobes in residents' rooms,
-surfaces of metal partitions in communal resident washrooms were scraped and/or paint chipped,
-gouges were evident in a number of tub room wall surfaces,
-the majority of lower door frame surfaces in resident rooms and washrooms were badly scraped and chipped,
-the majority of metal cabinets located in tub and shower rooms were rusty and/or soiled on interior surfaces where clean supplies were stored,
-the metal base of one overbed table provided in room#101 is scraped and soiled,
-several hand wash sinks in residents' washrooms were observed to have damaged inner bowl surfaces,
Note:Non intact surfaces cannot be effectively cleaned and sanitized or disinfected as needed presenting a potential infection prevention and control risk.

- a chrome or metal type of grab bar was pulling out of the wall at one of its 4 attachment points over the toilet in the communal washroom near room 116 which places residents at increased risk for falls
-the back rest mesh was missing from a commode/shower chair that was located over a toilet in the communal washroom adjacent to room 119 which is a safety risk to residents
-a section of hand rail is missing from the 1st floor corridor in the vicinity of the zone 8 exit stairway door which is a potential safety risk to residents who require the hand rail for support and/or ambulation.
-the ceiling surface was damaged in the tub room (located near room 116). The

plaster patching compound was cracked and rough and a sheet of blank paper was taped to the ceiling (reason is not known);ceiling surface is damaged around the exhaust vent grill in the washroom that is adjacent to room 114; ceiling tiles were stained in a number of areas through out the home.
-It was identified by staff that the roof leaks, which resulted into water infiltration into several 3rd floor areas.
Note: Moisture damaged surfaces are a potential safety risk related to mould growth and compromised ceiling surface integrity is a safety risk for surface failure and possible collapse.

-base board radiator covers are scraped in many bedrooms; protective baseboard heater covers were observed to be loose and/or misaligned in a number of rooms; loose rad covers which places residents at increased risk of harm from contact with sharp edges of radiator surfaces and at increased risk of burns from an unprotected source of heat.
-short pieces of cut off piping were protruding from walls in a number of areas: washroom adjacent to room 107; in the lounge near room 2006; in the 2nd floor "Spa room" near room 2006 which places residents at increased risk for skin tears and bruising.

-floor coverings were damaged with surfaces not intact in a number of areas: small dining room adjacent to room 101. There is a section of flooring missing that measures approximately 1 inch by 4 inches. Debris has built up in the exposed area of sub floor; the floor surface in the washroom that adjoins room 1019 has been patch with duct tape which is peeling and soiled; the floor covering in the tub room near room 216 is split open approximately 8 inches along a seam; the floor surface in room 215 is chipped in several areas; ceramic-type floor tiles and grout was chipped and cracked exposing crevices in the floor surface in a 2nd floor "Spa room" near room 2006. The textured tile floor surface in this tub room also was visibly soiled and discolored. The soiling scrapes off. Corridor carpeting in the vicinity of the 3rd floor nurses station and clean utility room is worn and fraying. Damaged flooring cannot be properly cleaned and is a potential tripping hazard when the surface is uneven.

-contents have separated in two of the water temperature testing thermometers located in the Willow binder and Cedar binder which would compromise the staff's ability to accurately identify water temperatures that may be too hot or too cold and present a risk to residents.
-commode/shower chairs with split plastic seats were present over a toilet in

communal washrooms adjacent to rooms 117 and 114. Cracked seats cannot be cleaned and disinfected properly and may also be a risk to resident comfort.

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

The Licensee failed to ensure that the resident, the resident's substitute decision-maker (SDM), or any other persons designated by the resident are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Interview of Resident#4727 indicated their medication had been recently increased and was not notified.

Review of Resident #4727 health records indicated one of the resident's medication was increased on two specified dates and there was no indication the resident was notified.

Review of Resident #4727 care plan related to decision-making indicated the resident was to be involved in decisions with regards to care.

2. Related to log #000447:

The licensee failed to ensure the resident's plan of care was reviewed and revised when the residents care needs changed related to transferring, toileting, bed mobility, and skin & wound care and when interventions identified were not effective.

Review of the progress notes for Resident #1 indicated:
-on a specified date a PSW reported while transferring and performing care, the resident sustained an injury. The resident was transferred to hospital for assessment as a result.
-five months later, the resident was found in bed with an injury.Treatment was provided and the resident was unable to indicate how the injury occurred.
-two months later, a referral from physiotherapy (PT) was completed for a "transfer assessment". The PT recommended the resident would be safer to transfer with a mechanical lift.
-two days later, a PSW reported the resident sustained an injury during care and transfer. The resident was not transferred as recommended by the PT.
-the following day, a new medication was ordered for care.
-seven days later,the PSW's reported when completing care, the resident became agitated and sustained an injury. There was no indication the resident received the medication as ordered.

Review of RAI-MDS had no indication of related risk for injury related to responsive behaviours during personal care or during transfers.

Review of incident reports for each incidents indicated the only actions taken were wound care treatment.

Review of the plan of care for Resident #1 indicated the resident required extensive assistance with two staff for transferring and was able to weight bear. There was no indication of the use of mechanical lift. The resident required total assistance of two staff for toileting due to responsive behaviours. It also indicated the resident is not toileted despite the resident being toileted. The plan of care also indicated the resident was at risk for skin breakdown due to incontinence, and inability to change position. There was no indication of the risk of skin breakdown related to responsive behaviours, transferring techniques or use of mobility aides.

There was no indication the mobility aides were assessed or the areas where the resident sustained injury was assessed to prevent re-occurrence. There was no indication when the resident sustained ongoing injuries, that potential contributing factors were identified and interventions to be used were based on current assessed needs (i.e.recommendations by PT and new medications) and other interventions were considered when current interventions were ineffective. [s. 6. (10)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The Licensee failed to fully respect and promote the resident's right to be afforded privacy in treatment and in caring for his or her personal needs.

On a specified date, two PSW's were observed providing personal care to Resident#004 in a semi-private room. The door was open and no curtains drawn. A room mate was also observed in the room. The PSW's (upon witnessing the inspector)drew the curtains around the resident. Interview with both PSW's (upon completion of care) reported expectations is for the door and/or curtains to be drawn during resident care.

2. On a specified date, care was observed being provided to Resident #003 with the privacy curtains not drawn and there were three other residents in the room at that time.

Interview of the Administrator, and RN#304 both stated "it is the expectation that staff provide privacy to each resident while providing care, by pulling the privacy curtain to surround the resident bed space".

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Residents rights are fully respected and promoted to ensure every resident is afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Under O. Reg. 79/10, s.89(1) As part of the organized program of laundry services under clause 15(1)(b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(iv) there is a process to report and locate residents' lost clothing and personal items.

Review of the home's policy "Missing Resident Laundry"(XII-K-20.50) which states "All missing personal clothing that is reported will be recorded on the Missing Laundry form (Form XII-K-20.50)and every effort will be made to locate them". The Procedure directs the PSW to ensure that the form is made readily available to families in each home area, to assist the resident/family in completing the form, to conduct a search of the residents' room and to report the lost item by forwarding the form to the laundry staff if the item is not found in the home area.

Interview of 10 resident's reported all having had missing clothing or laundry recently and reported it to the home.

Review of the home's complaint log for one year indicated there were 3 resident's/families that reported missing clothing or laundry (one of these were in the ten resident's interviewed). The complaint log for the following year had no documented reports of missing clothing or laundry.

Interview of the Manager of Environmental Services stated "the charge nurse is expected to fill out a Missing Laundry form when missing clothing or laundry is reported and forward to the Manager of Environmental Services".

Interview of 7 nursing staff members regarding the process for reporting and retrieving missing clothing or laundry indicated:
-6 of the staff members indicated a standardized form (if any) was not used.
-2 PSW's were provided a copy of the form "Missing Laundry" and stated they "were not familiar with the form".

The licensee failed to ensure the home's policy Missing Resident Laundry was complied with.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's polices for missing laundry are complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

A comfortable easy chair is not provided for every resident in a shared resident's room and several resident's rooms did not have a chair at all.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all residents are provided a comfortable easy chair, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. On March 21, 2014 Alenti lifts were observed in use in several of the tub rooms. The Alenti lifts observed in tub rooms on the 1st and 2nd floor did not have seat belts on or near each lift seat or available within the tub room. In one of the 1st floor tub rooms, the lift and the bath tub were visibly wet and a dry seat belt was hanging over a towel bar within the tub room.

Nursing staff who are involved in bathing residents and using the Alenti lifts identified that the seat belts are used for every resident. One staff member indicated that a seat belt is only used on the Alenti lift if the resident has a restraint order for a seat belt.

The "Alenti Operating and Product Care Instructions" manual was available in the home.Safety warnings are prominently identified with symbols. On page 3 of the instruction manual, the safety warning symbol description identifies that "Failure to understand and obey this warning may result in injury to you or to others". Safety instructions on page 4 of the manual identifies four safety warnings with symbols including "The safety belt must be used at all times to make sure the resident remains in an upright position in the middle of the seat."

The licensee failed to ensure that staff are using the Alenti lifts in accordance with manufacturers' instructions which places the residents at risk for injury from lifts (becoming unbalanced and tipping).

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use all equipment, devices, assistive aides in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to log # 000408:

A Critical Incident Report was submitted to the Director one day following the incident of resident to resident physical abuse that occurred. The CI indicated Resident #4774 was physically abusive towards Resident #4444 resulting in Resident #4444 sustaining an injury. There was no indication the Director was notified immediately.

A second Critical Incident Report was submitted approximately two months later to the Director one day following the incident of a resident to resident physical abuse that occurred. The CI indicated Resident #4774 was physically abusive towards Resident #4445 resulting in Resident #4445 sustaining an injury and the Director was not notified immediately.

Interview of the Administrator confirmed the Director was notified until the critical incident reports were submitted.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a person who has reasonable grounds to suspect abuse of a resident by anyone, the information upon which it is based is immediately reported to the Director, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The Licensee failed to ensure that each resident's personal items were labeled, as evidenced by the following:

Observed by Inspector #554:
-Room #202: two toothbrushes, comb, k-basin and dentures cups were not labeled; this washroom is shared by two residents.
-Room #209: a toothbrush and a urinal were not labeled; this washroom is shared by two residents and also used a communal washroom, which opens to the hallway.
-Room #2012: seven toothbrushes, two k-basins, a denture cup and a bedpan were not labeled in a shared washroom; this room is shared by three residents.
-Room #2016: two toothbrushes, a razor, 3 urinals and a specimen collection hat were not labeled in a shared washroom; this washroom is shared by three residents.

Observed by Inspector #555:
-Room #1006: a toothbrush and safety razors were not labeled in a shared washroom; this washroom is shared by three residents.

-Room #1004: a brush, bottle of mouthwash and deodorant spray were not labeled; this washroom is shared by 4 residents.
-Room #1009: toothbrushes, nail clippers, two bottles of mouthwash, deodorant and body wash were not labeled in a washroom shared by two residents.

An interview with the ADOC, indicated "that all personal care and grooming supplies are to be labeled for individual use, labeling is done on admission,and as the resident receives new items, and labeling is to be done by the PSW's". The ADOC also stated that the home "currently has no process or audits in place to ensure resident personal care supplies are labeled for individual use".

2. The licensee failed to ensure that resident's personal aids and equipment are cleaned as required.

The following was observed:
-Resident #4704 wheelchair frame and seat cushion were soiled.
-Resident #4776 wheelchair seat cushion was soiled.
-Resident #4805 wheelchair frame and seat cushion were soiled.
-Resident #4855 wheelchair frame, back rest on chair and seat cushion were soiled.

Review of the home's policy "Equipment Maintenance and Cleaning-Nursing and Resident Care" (VII-H-10.10) indicates:
-"with each use, observe cleanliness and safety of equipment and clean as required according to care and cleaning frequency schedule".
-This chart indicates the wheelchair cleaning will be as per the facility schedule.

Interview of the ADOC indicated the ADOC was "unaware of cleaning routines for wheelchairs and walkers".
Interview of RPN #303 stated "there is no routine cleaning schedules for wheelchair and walker cleaning that I'm aware of".

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home has his or her personal items, including personal aids are labelled within 48 hours of admission and when acquiring new items and are cleaned as required, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

The licensee failed ensure that the resident or the resident's substitute decision maker was notified of the resident's personal aids or equipment that were not in good working order or required repair, as evidenced by the following:

-Resident #4704: wheelchair arm rests(vinyl covering)were both torn and the Resident's right arm was observed resting on the steel frame of the arm rest. The right brake was also broken and missing the rubber tip.
-Resident #4776: wheelchair arm rest(vinyl covering)on the right side was cracked, the right brake was missing the rubber tip cover, and the tilt engagement mechanism was broken.
-Resident #4855: wheelchair back was broken with screws missing.

Interview with ADOC and the Administrator both indicated that a binder is located at each nursing station for wheelchair and walker maintenance and/or repair. The ADOC indicated that "families are notified of wheelchairs or walkers needing repair". The Administrator indicated that the external vendor (Shopper's)is responsible for repairs of individual resident mobility equipment.

Interview of RPN #303 indicated the PSW (or other staff) communicate the need for a resident wheelchair or walker to be repaired to the registered staff and the registered staff (usually RPN) will complete an on-line request for Shopper's to fix the resident equipment. RPN #303 and #309 indicated "no requests for equipment repairs had been forwarded to Shopper's for any of the above resident's personal mobility aides".RPN #303 indicated that families are not notified of wheelchair or walkers in need of repair but that "Shopper's notifies families".

Review of the health care record for Resident #4704, Resident #4776 & Resident #4855 progress notes had no indication that SDM's were notified of wheelchairs needing repair or maintenance.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident or the resident's substitute decision-maker is notified when the resident's personal aids or equipment is not in good working order or require repair, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

The Licensee failed to ensure that there are measures in place to prevent the transmission of infections.

The following were observed:
-Room #2016:three urinals were unlabeled and soiled, hanging on a towel bar in resident washroom shared by three residents.
-Room #2012:a bedpan was unlabeled and soiled in a resident washroom shared by three residents.
-Room #209:a urinal was unlabeled and soiled, sitting on the toilet tank in a resident washroom shared by two residents as well as a communal washroom as it opens to the hallway.
-Two days later, Rooms #2012 and #2016 items identified remained unlabelled and unclean.

Observation of all the green linen cart covers (for the clean linen) throughout the second floor on March 24 & 25, 2014 indicated they were soiled/stained.

2.Review of the home's policy "Equipment Maintenance and Cleaning–Nursing and Resident Care" (VII-H-10.10) indicted:
-with each use, observe cleanliness and safety of equipment and clean as required according to care and cleaning frequency schedule.
-the schedule indicates that bedpans, urinals and basins will be cleaned on a weekly basis.

Review of the "equipment cleaning sheets"located at the nursing station on'Maple unit' for March 2014 indicated the sheets were all blank.

Interview of PSW #305 and #308 stated "bedpans, urinals and basins are cleaned after each use using the tub disinfectant" but both PSW were unaware of any cleaning schedules.

Interview of RPN #303 stated "there is a night cleaning schedule for the cleaning of bedpans, urinals or basins" but was unaware of how often this occurred.

Interview of ADOC indicated that there was currently no specific cleaning routine for bedpans, urinals or basins, but it was a 'night duty'. The ADOC indicated this was an area currently being improving and stated they "had just put the equipment cleaning sheets into effect".

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there are measures in place to prevent the transmission of infections, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

Related to log # 000408:

A Critical Incident Report was submitted to the Director on a specified date for an incident of resident to resident physical abuse that occurred. The CI indicated Resident #4774 was physically abusive towards Resident #4444 resulting in Resident #4444 sustaining an injury and the police were not notified until the following day.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

The licensee failed to ensure that a verbal complaint made to the licensee was investigated immediately.

Review of progress notes for Resident #4669 indicated on a specified date and time, the resident reported missing money to RPN #112. A month later, the resident was interviewed but the resident could not recall when the money was lost.

Review of the home's complaint log for that time period indicated there was no documented evidence of a verbal complaint received by Resident #4669 regarding missing money.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all verbal and written complaints made to the licensee are immediately investigated and a documented record is kept in the home, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

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

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

Findings/Faits saillants :

The licensee failed to ensure that when a drug that is to be destroyed is a controlled substance, it will be done by a team acting together and composed of: one member of the registered nursing staff appointed by the Director of Nursing and a physician or pharmacist.

Review of log sheets for "Narcotic Disposal" indicated there were several dates over a two year period that only the signature of one RPN, or signatures by two RPN's, or signature by an RPN and the DOC were noted.

Interview with ADOC indicated that currently the destroying of controlled substances is completed with a registered nursing staff and the pharmacist, but was aware that only one staff member (or a team without a pharmacist) was destroying controlled substances in the past.

2. The licensee failed to ensure that where a drug that is to be destroyed, and is not a controlled substance, it will be done by a team acting together and composed of: one member of the registered nursing staff appointed by the Directory of Nursing and one other staff member appointed by the Directory of Nursing.

There was no documented evidence indicating non-controlled drugs are disposed of by a team acting together.

Interview with the ADOC indicated there was no evidence available indicating two staff witness the disposal of non-narcotics.

3. The licensee failed to ensure where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal shall document the following in the drug record:
8.The manner of destruction of the drug.

Review of "narcotic disposal records" indicated that on several specified dates, there was no indication of the manner of destruction recorded.

Interview with the ADOC indicated that drug disposal records had not included the manner of destruction.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances in the home are destroyed by a team acting together and composed of a registered nursing staff member and either a physician or pharmacist, that drugs destroyed in the home are completed with a team acting together, and that the destruction of drugs (including controlled substances) includes the manner of destruction, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

The Licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On a specified date, an RPN was observed dispensing oral medications from a blister pack into the RPN's hand prior to placing them into the medication cup and administering it to the resident. Interview with the RPN confirmed touching of resident's oral medications was not following proper infection control practices.

On a specified date the following was observed:
-two PSW's left soiled incontinence products and soaker pad on the floor while providing personal care to a resident.
-multiple residents' rooms noted personal care products such as toothbrushes, deodorant, body wash, hair brushes, mouthwash, clippers, and razors in shared bathrooms not labelled.
-one resident's room had a floor mat(for falls) hanging off the top of a wardrobe.
-a garbage pail sitting on the rim of a tub.

2. The Licensee failed to ensure that each resident admitted to the home was screened for Tuberculosis(TB) within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available.

Review of the home's policy "Tuberculosis Screening and Mantoux Testing" (VII-E-10.40) directs that residents, either before or within 14 days of admission, screened using Mantoux unless the resident has a known TST positive or is medically contraindicated. The policy further directs that results will be read in 48-72 hours.

Interview of ADOC indicated the home only began following the Durham Public Health guidelines for TB screening in the past few weeks but the home's policy was not yet updated.

Review of the health care records indicated:
-Resident #4855 was not administered TB screening until three months after admission.
-Resident #4893 was not administered TB screening until three weeks after admission and the 2nd Step results remained unread.

3. The Licensee failed to ensure residents are offered immunization against influenza

at the appropriate time each year.

Review of health records indicated:
-Resident #002 had SDM consent for vaccination but no documented evidence of being offered the vaccination.
-Resident #001 had SDM consent for vaccination but no documented evidence of being offered the vaccination.

4. The Licensee failed to ensure that staff are screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Review of the home's policy "Tuberculosis Screening and Mantoux Testing" (VII-E-10.40)(Revised Nov. 2011) directs that "all staff, as a condition of employment, new staff will provide proof of negative Mantoux prior to their orientation".

Review of employee health records indicated:
- Employee #300 had no documented evidence of TB screening.
- Employee #301 did not have TB screening completed until four months after hire.

Interview of the ADOC (acting Infection Control Coordinator) indicated that only the nursing department was monitored by the ADOC and "did not track TB testing for new employees in other departments and was the responsibility of each department manager".

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of infection prevention and control; ensure that all residents admitted to the home are screened for TB within 14 days of admission, unless the resident has results available indicating the resident was already screened within 90 days prior to admission; that all residents are offered influenza at the appropriate time each year, and staff are screened for TB and other infectious diseases in accordance with evidence-based practices, or if none, in accordance with prevailing practices, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee failed to ensure that the home is a safe and secure environment for its residents.

On March 17, 2014 at 11:22 hrs the door entering to the laundry chute on the 2nd floor was not locked and the chute was also not latched. The inspector was able to fully open the unlatched chute. The environmental service manager was across the hall and overheard Inspectors 551 and 555 talking about the unlatched chute and came to latch the chute at 11:23.

On March 18, 2014 at approximately 15:25 hrs, Inspectors#555 and #551 noted that the door to the laundry chute on the first floor was not locked and the chute was not latched. The registered staff assigned to the floor was informed and the lock to the chute was latched.

On March 20, 2014, Inspector #551 noted a latch type lock had been installed on the door leading to the chute room and a sign had been posted to remind staff to ensure that the chute access door was locked.

This unrestricted, unsupervised access to the chute's presents the potential for risk of injury to all residents on the first and second floors and action was taken as a result of the inspection.

2. Related to log# 000399:
A Critical Incident report indicated on a specified date, Resident#997 sustained an injury in an area that was to be inaccessible to residents.

Observation of the area indicated the area was now restricted to prevent accessibility.

Interview of the Manager of Environmental Services stated the restriction was applied only recently despite the incident occurring over a year ago.

This unrestricted access to the area presented an actual risk of injury to Resident#997 (and potential risk to all other residents), but action was not taken to restrict access until recently when a barrier was put in place which now effectively prevents the unsafe condition.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

Related to log# 000399:

The licensee failed to ensure that when a resident has fallen, a post-fall assessment is conducted using a clinically appropriate assessment that is specifically designed for falls.

Review of the progress notes for Resident #997 indicated on a specified date, the resident sustained a fall resulting in injury after accessing an area that was to be restricted.

There was no documented evidence of a post fall assessment completed using a clinically appropriate assessment tool specifically designed for falls.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

Related to log #000408:

A Critical Incident Report was submitted to the Director the day after the incident of resident to resident physical abuse resulting in injury that occurred.The CI indicated Resident #4774 was physically abusive towards Resident #4444 resulting in injury to Resident #4444.The CI indicated the short term actions taken was placing the resident on every 15 minute checks and the long term actions were a referral to Ontario Shores.

Review of the progress notes for Resident #4774 indicated the resident was observed being physically abusive towards Resident #4444 on the specified date which resulted in injury to Resident #4444.The progress notes also indicated that five months prior to this incident, the resident was observed being verbally and physically abusive towards Resident#4444 resulting in injury towards Resident #4444. Approximately 3 months after this incident, Resident #4774 was observed being physically abusive towards Resident#4445 resulting in injury and was verbally abusive towards other unidentified resident's.

Interview of PSW #308 regarding Resident #4774 behaviours, stated "if the resident cannot get to where the resident wants to go, the resident will start to get angry, curse, and may hit". The PSW indicated that most of the staff are aware of the resident's behaviors, will try to facilitate movement in common areas, the resident is easily agitated/angered, staff try not to engage the resident when the resident is angry, staff try to keep other residents away when resident is moving to allow easy movement however some residents will intentionally try to block hallway to antagonize others.

Interview with RPN #109 stated "the resident does not want to be inconvenienced in any way and if has to wait, becomes agitated, mumbles and swears".

Review of the care plan for Resident #4774(in place at the time of the first incident) did not include any behavior triggers or interventions related to the responsive behaviours of resident to resident verbal and physical abuse.

Review of the care plan for Resident #4774(in place at time of the second and third incidents) did not include any interventions for managing the resident's responsive behaviours of physical abuse towards other residents when the resident in common areas and/or need for immediate access delayed.

The licensee failed to ensure that when a resident demonstrated responsive behaviors of verbal and/or physical abuse towards other residents, the behavioral triggers for the resident were identified, where possible. The licensee also failed to ensure that when a resident demonstrated responsive behaviours of verbal and/or physical abuse towards other residents, strategies were developed and implemented to respond to these behaviours, where possible.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

s. 90. (3) The licensee shall ensure that the home's mechanical ventilation systems are functioning at all times except when the home is operating on power from an emergency generator. O. Reg. 79/10, s. 90 (3).

Findings/Faits saillants :

The licensee failed to ensure that policies and procedures were developed and implemented regarding the use of mechanical tub lifts.

Review of the "Preventative Maintenance Schedule-Alenti" contains an Alenti "Operating and Product Care Instructions" starting on page 23. Page 24 explains the preventative maintenance schedule and identifies 7 "Action/check" points that are to be performed weekly on each lift.

Interview of staff of the home confirmed that the prescribed 7 checks were not being performed and it was noted that the lifts are only inspected annually by a contractor.

There was no documented evidence of any policies or procedures to ensure that the ARJO Alenti tub lifts (used in tub rooms) were cleaned and maintained at a level that meets the manufacturers' specifications. [s. 90. (2) (a)]

2. The licensee failed to ensure that procedures were implemented to ensure that the mechanical ventilation system is functioning at all times.

Observation of exhaust vents were not operational in washrooms (near rooms 102 and 105) and in the communal washroom (near room 216). The exhaust ventilation fan or vent was missing from the ceiling in the washroom of room #1007's.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

The Licensee failed to ensure staff apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class.

On March 18, 19 & 20, 2014 Resident #4654 and Resident #4668 were observed in wheelchairs wearing a seat belt that was fastened across the residents' lap.

A review of the physician's orders for Resident #4654, indicated the order for use of a seat belt was discontinued 7 months prior.
A review of the physician's orders for Resident #4668, indicated the order for use of a seat belt was discontinued 3 months prior.

Interview with RPN #303 and RN#304, indicated that Resident #4654 & Resident #4668 "could not release the seat belt" and "would require staff to release". Both staff indicated that both resident's were "not to be wearing a seat belt, as there was no physician's order". [s. 110. (2) 1.]

2. On March 19 and 20, 2014 Resident #4776 was observed in a wheelchair with a seat belt fastened across resident's lap.

A review of the physician's orders confirmed that there was no current order for a seat belt restraint.

Interview with RPN #309 and RN #304 stated that the Resident "could not release the seat belt" and "would require staff to release". RN #304 stated the "resident was not to be wearing a seat belt as there was no physician's order".

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that drugs stored in a medication cart are kept locked at all times, when not in use.

On a specified date and time, RPN #136 was observed leaving the medication cart unlocked and unattended in the hallway when entering a Resident's room.

Interview with RPN #136 indicated that the expectation is for medication cart to be locked when not in attendance. [s. 129. (1) (a)]

2. The licensee failed to ensure that all controlled substances are stored in a separate, double-locked stationary cupboard in the locked area.

Observation of the narcotics for disposal were stored in a single-locked container within the Nursing Office.

Interview with the ADOC and Nursing Office staff indicated the Nursing office door is occasionally left open and unattended.

The single-locked container was moved to a locked closet within the ADOC office as a result of the inspection and only the ADOC has the key.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

The licensee failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

Review of the health care record of Resident #4893 indicated the resident had a new Physician's order to be initiated.

Inspector #555 observed PSW #137 inform RPN #122 that the drug had been initiated for Resident#4893 as requested. Observation of Resident#4893 indicated the resident was observed receiving the drug.

Interview of RPN #122 confirmed that PSW #137 had initiated the new order under the RPN's direction. The RPN confirmed that the new order was a drug but was uncertain if the PSW's were able to initiate it.

Interview with ADOC indicated that PSW's are not delegated the ability to initiate administration of the drug and only registered staff are responsible for administration of the drug.

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

Issued on this 8th day of May, 2014

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


Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), GWEN COLES (555), KELLY BURNS (554), MEGAN MACPHAIL (551), WENDY BERRY (102)
Inspection No. / No de l'inspection :	2014_220111_0006
Log No. / Registre no:	O-000205-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 9, 2014
Licensee / Titulaire de permis :	Glen Hill Terrace Christian Homes Inc. 200 Glen Hill Drive South, WHITBY, ON, L1N-9W2
LTC Home / Foyer de SLD :	STRATHAVEN LIFECARE CENTRE 264 King Street East, Bowmanville, ON, L1C-1P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PATRICK BROWN

To Glen Hill Terrace Christian Homes Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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Ontario

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Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will ensure that every resident bedroom occupied by more than one resident is equipped with sufficient privacy curtains to provide privacy.

Grounds / Motifs :

1. Resident rooms occupied by more than one resident do not have sufficient privacy curtains to provide privacy when overhead lifts are in motion in rooms 3002, 3003, 3005, 3007, 3009.
Note: this issue was identified and was to be addressed prior to admission of residents to the short stay program (interim) beds on the 3rd floor. (102)

2. The Licensee failed to ensure that each resident's bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

Privacy curtains were not provided to ensure sufficient privacy in the following rooms which are occupied by more than one resident:
-Room 204 (occupied by two residents), the privacy curtain between both resident's is obstructed by the ceiling lift; there was no privacy curtain in place for the resident in bed #1; the privacy curtain for the resident in bed #2 was short by three feet.
-Room 209 (occupied by two residents), the privacy curtain between both residents is obstructed by the ceiling lift and one resident's curtain is short by two feet.
-Room 2012 (occupied by four residents), is not easily movable along the track; the curtain used to enclose the bed space for Resident #4752 is approximately 2 feet short; the overhead lift does not allow the privacy curtains enclosing bed #2 and #3 to remain closed when the lift is in motion on the track; the resident in bed #2 privacy curtain is obstructed by the ceiling lift track.
-Room 2016 (occupied by three residents), specific to bed #2 is obstructed by the ceiling lift cord and prevents privacy when the ceiling lift is in motion along the track;the privacy curtain for bed #3 is approximately 3 feet short enclosing the bed and at minimum of 1.5 feet short in separating bed #2 and #3.

(554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 02, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee will ensure that the resident staff communication and response system is provided in all areas that are accessible to residents.

Grounds / Motifs :

1. The resident staff communication and response system is not available in the following resident accessible areas:
- lower level hair salon
- lower level physio room
-lower level activity room

The lack of availability of the resident staff communication and response system in areas accessible to residents is a potential risk to the health, safety and well being of residents. (102)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 09, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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.
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

Order / Ordre :

The licensee will ensure that required levels of lighting are provided in all areas of the long term care home including:
• A minimum of 215.28 lux of continuous consistent lighting in corridors;
• A minimum level of 215.28 lux in all residents' bedrooms, program/lounge space, dining areas, washrooms and tub and shower rooms.

The licensee will provide a written progress report to indicate the status of the correction of the lighting levels by October 1, 2014.

This progress report must be submitted in writing to the MOHLTC, Attention: Wendy Berry, Fax (613)569-9670.

Grounds / Motifs :

1. Light levels were checked during the inspection on March 21 and 24, 2014. A "G.E." model light meter was used. The light meter was held 3 to 4 feet above the floor surface; all available electric lights were turned on in each area being checked. In bedrooms, window coverings were closed; privacy curtains were open, where provided.

Light levels of less than 25 % to 50 % of the required lighting level of 215.28 lux was provided in the majority of residents' bedrooms on the 1st and 2nd floors.

1st and 2nd floor corridor lighting levels were less than 25 % to 50 % over the majority of the length of each corridor. 215.28 lux of continuous, consistent lighting is not provided throughout the corridors.

Lighting in several residents' washrooms and common rooms was identified to be below 50 % of the required illumination level of 215.28 lux: washrooms that adjoin rooms 208, 2000, Lounge adjacent to room 2006, washroom near room 102. This is not an all inclusive list as all areas were not entered and checked with a light meter.

Insufficient levels of illumination are a potential risk to the health, safety, comfort and well being of residents. Residents' visual acuity and perception of surroundings may be compromised. (102)

Ontario

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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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 10, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will prepare, implement, and submit a corrective action plan to ensure that the home, furnishings and equipment are maintained in safe condition and in a good state of repair including:
-repairing, refinishing and/or replacing, as appropriate, all damaged floor surfaces with cracks, crevices, rips and open seams; all damaged wall, door frame, door, and ceiling surfaces that are gouged, scraped, rough and broken; all ceiling tiles that are broken, missing or have stains resulting from moisture damage; all metal toilet stall partitions, baseboard heater covers and over bed tables that are scraped, gouged, rust evident; all wash basins/sinks with chipped, worn interior surfaces; all wood handrails, chair frames and clothing wardrobes with chipped, worn, non-intact surfaces;
- hand rails are to be replaced where missing from corridor walls;
-commodes and shower chairs with cracked, split or missing parts are to be removed from use and replaced, as per resident need;
-roof leaks are to be repaired as soon as weather and exterior conditions allow;
-baseboard heater protective covers are to be kept in place;
-damaged water temperature thermometers are to be discontinued from use and replaced, as needed. Thermometer calibration is to be checked to verify accuracy;
-cut off pipes protruding from wall surfaces in resident areas are to be removed and/or covered.

The corrective action plan is to be submitted by April 22, 2014. This must be submitted in writing to the MOHLTC, Attention: Wendy Berry, Fax (613)569-9670.

Grounds / Motifs :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and a good state of repair which is a potential risk to the health, comfort, safety and well being of residents.

The following area were identified:
- walls in the majority of bedrooms were scraped and/or damaged exposing a non-intact surface that can not be effectively cleaned,
-the finish had worn from wooden handrails through out corridors on all floors and wood handrails were also identified to be loose in 2 areas(which were tightened upon notification to the Environmental Services Supervisor),
-the finish was scraped and worn from wood frames on many of the chairs that are provided for resident use,

- the finish has scraped, chipped and/or worn from the lower surfaces of the majority of wardrobes in residents' rooms,
-surfaces of metal partitions in communal resident washrooms were scraped and/or paint chipped,
-gouges were evident in a number of tub room wall surfaces,
-the majority of lower door frame surfaces in resident rooms and washrooms were badly scraped and chipped,
-the majority of metal cabinets located in tub and shower rooms were rusty and/or soiled on interior surfaces where clean supplies were stored,
-the metal base of one overbed table provided in room#101 is scraped and soiled,
-several hand wash sinks in residents' washrooms were observed to have damaged inner bowl surfaces (example: room 1016, 1012),
Note:Non intact surfaces cannot be effectively cleaned and sanitized or disinfected as needed presenting a potential infection prevention and control risk.

- a chrome or metal type of grab bar was pulling out of the wall at one of its 4 attachment points over the toilet in the communal washroom near room 116 which places residents at increased risk for falls
-the back rest mesh was missing from a commode/shower chair that was located over a toilet in the communal washroom adjacent to room 119 which is a safety risk to residents
-a section of hand rail is missing from the 1st floor corridor in the vicinity of the zone 8 exit stairway door which is a potential safety risk to residents who require the hand rail for support and/or ambulation.
-the ceiling surface was damaged in the tub room (located near room 116). The plaster patching compound was cracked and rough and a sheet of blank paper was taped to the ceiling (reason is not known);ceiling surface is damaged around the exhaust vent grill in the washroom that is adjacent to room 114; ceiling tiles were stained in a number of areas through out the home.
-It was identified by staff that the roof leaks, which resulted into water infiltration into several 3rd floor areas.
Note: Moisture damaged surfaces are a potential safety risk related to mould growth and compromised ceiling surface integrity is a safety risk for surface failure and possible collapse.

-base board radiator covers are scraped in many bedrooms; protective baseboard heater covers were observed to be loose and/or misaligned in a

number of rooms; loose rad covers which places residents at increased risk of harm from contact with sharp edges of radiator surfaces and at increased risk of burns from an unprotected source of heat.
-short pieces of cut off piping were protruding from walls in a number of areas: washroom adjacent to room 107; in the lounge near room 2006; in the 2nd floor "Spa room" near room 2006 which places residents at increased risk for skin tears and bruising.

-floor coverings were damaged with surfaces not intact in a number of areas: small dining room adjacent to room 101. There is a section of flooring missing that measures approximately 1 inch by 4 inches. Debris has built up in the exposed area of sub floor; the floor surface in the washroom that adjoins room 1019 has been patch with duct tape which is peeling and soiled; the floor covering in the tub room near room 216 is split open approximately 8 inches along a seam; the floor surface in room 215 is chipped in several areas; ceramic-type floor tiles and grout was chipped and cracked exposing crevices in the floor surface in a 2nd floor "Spa room" near room 2006. The textured tile floor surface in this tub room also was visibly soiled and discolored. The soiling scrapes off. Corridor carpeting in the vicinity of the 3rd floor nurses station and clean utility room is worn and fraying. Damaged flooring cannot be properly cleaned and is a potential tripping hazard when the surface is uneven.

-contents have separated in two of the water temperature testing thermometers located in the Willow binder and Cedar binder which would compromise the staff's ability to accurately identify water temperatures that may be too hot or too cold and present a risk to residents.
-commode/shower chairs with split plastic seats were present over a toilet in communal washrooms adjacent to rooms 117 and 114. Cracked seats cannot be cleaned and disinfected properly and may also be a risk to resident comfort. (102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 10, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
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Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is to reassess Resident#1, review and revise the written plan of care for Resident #1 (based on that assessment of the Resident), related to transferring, toileting, bed mobility and risk for skin breakdown and to implement the revised plan of care to ensure it is based on the resident's current assessed care needs and that interventions identified, are effective in reducing the risks associated with transferring, toileting, bed mobility and skin breakdown.

Grounds / Motifs :

1. Related to log #000447:

The licensee failed to ensure the resident's plan of care was reviewed and revised when the residents care needs changed related to transferring, toileting, bed mobility, and skin & wound care and when interventions identified were not effective.

Review of the progress notes for Resident #1 indicated:
-on May 26, 2013 at 20:15 hrs the PSW reported while performing bedtime care, the resident was standing (with walker in front and wheelchair behind) when the resident became restless and began moving the legs in a stepping motion. The PSW reported the foot rests were up and back but not all the way. The PSW then noted the resident sustained a large laceration to the right lower leg. The resident was transferred to hospital and returned to the home later with 13

sutures to right lower leg.
-on October 6, 2013 at 0800hrs a housekeeping staff member found the resident in bed with a large skin tear on the right forearm.Treatment was provided to the area and the resident was unable to indicate how the injury occurred.
-on December 6, 2013 a referral from physiotherapy (PT) was completed for a "transfer assessment". The PT indicated the resident has difficulty following directions/instructions. During the resident transfer,the resident was not weight bearing. PT recommended that the resident was not safe to be transferred with assistance of 2 staff and would be safer to transfer resident with hoyer lift.
-on December 12, 2013 the PSW reported the resident sustained a skin tear on the tip of the right index finger, during morning care when the resident grabbed the room mate's bar and sliced open the index finger. The PSW reported the resident "was resistive to care +++, grabbing and crying".
-on December 13, 2013 a new medication Trazadone was ordered for "pre-care" in am and HS "to prevent injury to staff during care and reduce agitation to patient" and to be reassessed in two weeks.
-on December 20, 2013 at 0800, the PSW's reported when they went to do a.m. care, the resident began yelling and before they actually got to the resident, they noted a large skin tear on the resident's left upper arm.

Review of RAI-MDS (November 2013) had no indication of skin tears or risks of skin tears related to responsive behaviours or transfers.

Review of incident reports for each skin tear incidents indicated the only actions taken were wound care treatment.

Review of the plan of care for Resident #1 indicated the resident required extensive assistance with two staff for
transferring and was able to weight bear. There was no indication of the use of a mechanical lift. The resident required total assistance of two staff with toileting due to responsive behaviours. It also indicated the resident is not toileted despite the resident still being toileted. The plan of care also indicated the resident was at risk for skin breakdown due to incontinence, and inability to change position. There was no indication of the risk of skin breakdown related to responsive behaviours, transferring techniques or use of mobility aides.

There was no indication the mobility aides were assessed or the areas where the resident sustained injury was assessed to prevent re-occurrence. There was no indication when the resident sustained ongoing injuries, that potential

contributing factors were identified and interventions to be used were based on current assessed needs (i.e. recommendations by PT and new medications) and other interventions were considered when current interventions were ineffective. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 11, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

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Ministére de la Santé et des Soins de longue durée

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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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of April, 2014

Signature of Inspector / Signature de l'inspecteur : L Brown

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

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