Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 18, 2014	2014_362138_0015	O-001107-14	Resident Quality Inspection

Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD SUITE 301 MISSISSAUGA ON L5N 2X4

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

PERTH COMMUNITY CARE CENTRE
101 CHRISTIE LAKE ROAD R. R. #4 PERTH ON K7H 3C6

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

PAULA MACDONALD (138), ANANDRAJ NATARAJAN (573), LYNE DUCHESNE (117), RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 3, 4, 5, 6, 7, 10, and 12, 2014

Two Critical Incident Inspections for log O-000765-14 and O-001088-14 were conducted and incorporated within the RQI.
A Follow Up Inspection was conducted concurrently for Logs O-000722-14 and O-000723-14 however the inspection is captured on a separate report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Office Manager, Director of Resident Care (DRC), RAI/Educator Coordinator, Activity Coordinator, Food Service Manager, Environmental Coordinator, Maintenance Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Residents, Past President of the Family Council, Family Members, President of the Residents Council, and Restorative Care Aide.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

14 WN(s)
7 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The Licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 cm.

On November 3, 2014, during initial observations of resident rooms during Stage 1 of the Resident Quality Inspection (RQI), Long Term Care Homes (LTCH) Inspector #548 observed windows on the first floor in resident rooms 160, 161, 162, and 163 to open more than 35 cm. It was also observed that two of these rooms, 160 and 162, did not have screens in place over the windows that opened.

LTCH Inspector #573 observed on the second floor in resident rooms 238, 240, 241, 243, 244, 249, 250, and 252 that there were sliding windows which can open on either side to an opening of 22 cm. It was also noted that these windows are equipped only with a half screen that was not sufficient to cover the possible openings on each side of the window.

On November 7, 2014, LTCH Inspector #573 spoke with the home's Maintenance Coordinator who stated that all the sliding windows on second floor will open 20 cm to 25 cm and are placed with half screens. The Maintenance Coordinator also stated to the inspector that he was aware that the windows accessible to residents on first floor open more than 15 cm.

On November 7, 2014, both the Maintenance Coordinator and Administrator indicated to LTCH Inspector #573 that they were unaware of the requirements of section 16 of the regulation. The Administrator further stated that she will arrange to make the necessary modifications to the windows within the next day or two to ensure windows do not open more than 15 cm.

On November 12, 2014, LTCH Inspector #138 observed while walking up to the home

from the parking lot that morning that there was a window in a residential area opened more than the allowable amount of 15 cm. After entering the building, the inspector proceeded to the first floor Bathurst wing and located the opened window at the end of the residential hallway next to the E1 stairwell door. The window was located on the bottom left side of the end of the hallway and measured approximately two feet by two and a half feet in dimensions. The inspector noted that the window was opened approximately 25 cm and that it could be fully opened by using the window crank. The inspector noted that the ground outside the window was approximately four feet below. It was also noted that at the end of the grounds was a main road and railway tracks. LTCH Inspector #138 spoke with the Administrator regarding the opened window on Bathurst wing. The Administrator stated that she was under the belief that the Maintenance Coordinator had ensured all windows were modified so that they could not be opened more than the allowable amount.

LTCH Inspector #573 spoke with the Maintenance Coordinator on November 12, 2014 regarding the concerns related to windows in the resident rooms and common areas which were opening more than 15 cm. The Maintenance Coordinator stated that, to-date, all the windows were not completely fixed and that he is currently working to do necessary modifications. [s. 16.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. The Licensee failed to comply with section 6.(1)(a) of the Act in that the Licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Resident #033 is identified at being at a high risk for falls. The resident was observed during the RQI to have various fall prevention interventions in place. These included the use of a fall mat, a high-low bed, a self-propelled wheelchair with tab alarm and a motion sensor. Staff #138 who was a PSW, Staff #105 who was an RPN, and Staff #139 who was an RN were interviewed by LTCH Inspector #117 and these staff stated that the above mentioned interventions have been in place for several months as the resident is at risk of falls. These staff members also stated to the inspector that they always ensure that these interventions are in place as the resident regularly tries to ambulate and transfer in and out of bed independently. The inspector reviewed Resident #003's current plan of care (as directed by the home) and noted that the above listed fall prevention interventions were not identified. [O-001088-14]

Another resident, Resident #032, had witnessed falls in May and June 2014 with no injuries. The resident was assessed and seen by physiotherapy services. According to Staff #111 and #123 who were PSWs, and Staff #118 who was a Restorative Care Aide, a fall mat, the use of a wheelchair, and relocation of the resident's bed against a wall

were some of the fall prevention interventions implemented by nursing staff in response to the falls. LTCH Inspector #117 reviewed the resident's plan of care of May 2014 and noted that the plan of care was not revised to reflect the falls prevention interventions implemented according to the interviewed staff members. [O-000765-14] [s. 6. (1) (a)]

2. The Licensee failed to comply with section 10 (b) of the Act in that the resident was not reassessed and the plan of care was not reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #032 was admitted to the home late in 2013 with multiple health problems.

In December 2013 and January 2014 the documentation on the resident's health care record indicates that Resident #032 started having inappropriate social behaviours towards staff members and other residents. On November 12, 2014, a RN, Staff #134, stated to LTCH Inspector #117 that the resident did have frequent inappropriate social behaviours and that these were not always documented in the resident's health care record. No other information related to the resident's behaviours and behavioural management interventions were found in the health care record. A review of the resident's quarterly care needs reassessment, completed in March 2014, did not identify that the resident had inappropriate social behaviours as documented occasionally in the health care record but mostly confirmed by staff. The resident's plan of care did not identify the assessment of the resident's inappropriate behaviours nor interventions implemented to manage these behaviours.

Secondly, in March 2014, the same resident was transferred and admitted to hospital due to ongoing symptoms of an existing diagnosis. The resident was treated and returned to the home several days later. Progress notes in the resident's health care record indicated that, after the hospitalization, the resident had several more episodes of the same symptom while in the home. Documentation on the health care record indicated that the resident consulted a specialist in May 2014 related to the symptom and returned to the home with medical directions to monitor for any other signs and symptoms and possible pain. Further documentation in the health care record notes that there were discussions regarding possible treatments for the resident's diagnosis, however, the plans of care in effect at that time were not revised to reflect the resident's changing needs relating to the resident's diagnosis, symptom, and the need to monitor the resident's condition.

Thirdly, in June 2014, the same resident expressed having severe pain in which the resident was sent to the hospital. Resident #032 was returned to the home pain management interventions. Documentation in the resident's health care record indicated that these interventions were again applied. During the next few days, Resident #032 continued to complain of pain and interventions were initiated. The resident's plan of care was reviewed and noted that it was not revised in response to the resident's changing needs relating to pain and pain management interventions.

Lastly, in June 2014, the same resident sustained a fall. The resident was assessed, transferred, and admitted to hospital with a diagnosis of a fracture. The resident had surgical repair and was readmitted to the home with new medical orders, a catheter, and pain management interventions. No information related to the resident's fracture, surgical intervention, post fracture care, pain management interventions, catheter care, and physiotherapy was identified in the resident's plan of care.

On November 12, 2014, Staff #118, Staff #123, Staff #130, and RN Staff #134 stated to LTCH Inspector #117 that they did not have a plan of care for Resident #032's changing care needs. They stated that the resident's changing care needs were communicated to them during morning shift reports. The RN, Staff #134, stated that all of the resident's care issues were identified and communicated during shift reports. The RN confirmed that the plan of care for the resident was not revised related to changes in the resident's care needs for inappropriate social behaviours, pain, symptoms, and fracture. [O-000765 -14]. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are reassessed and the plan of care revised when there are changing care needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to comply with section 15(2)(c) of the Act in that the Licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following are observations with respect to the home that were made by the LTCH Inspectors throughout the course of the RQI.

There were several wall, door, and door frame areas that were heavily scuffed, chipped, scratch and gouged. Specifically:
*Room 121 - There were horizontal scratches down to the metal on the bottom foot of the interior side of both bathroom doors. Inside the bathroom, there were scratches in the drywall by the grab bar with flecks of paint sticking out. There was also a dent in the drywall by the grab bar that has not been fully repaired.
*Room 125 - The door frame to the bathroom was chipped to the metal and heavily scratched at the bottom.
*Room 114 - The wall with the bathroom door had horizontal scuff marks eighteen inches from the bottom of the wall running across the wall for a three foot section.
*Room 141 - There were horizontal scratches to the metal on the bottom one foot of the interior side of both bathroom doors. The door to room 141 had thick deep horizontal scratches above the metal kick plate that ran three quarters of the way across the door.
*Room 152 - The door to the resident bathroom was chipped at the bottom eighteen inches of the door, exposing the metal beneath.
*Room 162 - The wood door frame to the resident washroom was heavily scarred at the bottom foot. There was also a large patch to the ceiling above the resident's bed that has not been painted.
*Room 244 - The door to the room was chipped to the metal along the edge from waist

height to the bottom. Both the interior bathroom doors had horizontal scratches to the metal in the area two feet to the bottom of the door. The door frame to the washroom doors was scratched to the metal from the waist level to the floor.
*Room 247 - The door to the resident washroom was chipped along the edge from waist level to the floor. The interior side of the two washroom doors and the door frames were scratched to the metal with horizontal lines at the bottom two feet.
*Room 252 - The wall that has the resident bathroom was heavily scarred from the bathroom door along the drywall for a five foot section. The scarring consisted of large chip marks down to the drywall and many black horizontal scuff marks that started from the bottom and continued two feet up the wall. Similar markings were found on the wall to the right as one enters the room and again on the opposite wall under the window. Both interior bathroom doors had horizontal scratches at the bottom two feet of the door. The door to the resident room was also heavily chipped along the edge from the door handle to the floor.
*Room 265 - The door frame to the resident room was heavily scratched to the metal from the waist level to the floor.
*Room 266 - The door into the resident room was scratched to the metal with short horizontal scratches and chipped along the edge from the handle to the bottom of the door. The wall in the entrance of the room is marked with horizontal scuff marks. The wooden frame into the resident washroom was heavily scuffed and dented at the bottom two feet.
*Perth wing hallway - The door frames to resident rooms 143, 144, 147,149, 150, 140, 152, 138, 136, 143, 134 were heavily scratched to the metal at the bottom of the frame, one foot from the floor. In addition, the lower portion of the wall between homes 136 and 138 (approximately 10 feet in distance) and between 140 and 143 (approximately 25 feet in distance) had horizontal scratches, chipped paint, scuff marks, and drywall damage.
*Bathurst wing hallway - The door frames to resident rooms were heavily scratched to the metal about one foot from the bottom for rooms 107, 109, 111, 112, 114, 116, 118, 120, 121, 123. In addition, the wall from the spa room to room 107 was scarred with long black scuff marks in the area approximately one foot from the bottom of the wall.
*Hart wing hallway - The door frames to resident rooms were heavily scratched to the metal about one foot from the bottom for rooms 160, 161, 163, 162, 164, 165, 166, 167, and 168. The door to the spa room was also heavily scarred and marked near the bottom of the door.
*Ontario wing hallway - The door to the spa room was scarred and scratched in a section at the bottom of the door not covered by the metal kick plate.
*Lanark wing hallway - There were scratches to the drywall above the handrail between rooms 234 - 238.

*Wiseman wing hallway - An approximate ten foot area on the wall and doors to the clean and soiled utility rooms was scratched with jagged black marks that also caused chipping of the surface paint in some areas. The doors that lead to the hallway where the dining room is located had horizontal scratch marks above the metal kick plate. The door frame for these doors was also heavily chipped to the metal near the bottom of the frame. The bottom of the interior door of the spa room on Wiseman had areas were the paint was peeling from the door leaving sharp, protruding edges of paint.
*Second floor lounge - The half wall by the ramp was scarred and chipped to the drywall in large areas that ran intermittently along the entire wall that was approximately 25 feet. The lounge wall that continues into the Lanark wing also had three horizontal scratches at chest level that each run a foot in length.

The floors in areas of the home were noted to be in disrepair. It was observed that there were several tiles in the vestibule at the main entrance that were loose and broken. It was also noted that the tile floor in the first floor lounge area had areas where the tiles were broken and grout between the tiles was missing. The tile floor in the spa room on the Bathurst wing was observed to be uneven in an area measuring six by six feet near the entrance to the spa room. Staff #140, who is a PSW, stated that the tile flooring in the Bathurst spa room is a concern because it is a potential tripping hazard for residents.

Several of the spa rooms in the home had wall surfaces that were is disrepair. The spa room on the first floor in Bathurst wing had 22 tiles broken under the radiator next to the tub and 9 more broken tiles on the opposite wall. The spa room on Hart wing had 3 rows of 5 tiles on the window sil that have sunk and exposed the wood and insulation in the walls. On second floor, the spa room on Ontario had 21 tiles missing on the wall behind the tub exposing the unfinished drywall where the plumbing was located. There was also chipped and partially missing tiles on the corner wall by the toilet exposing the dry wall underneath. The spa room on Wiseman also had broken tiles on the wall that exposed wood and drywall beneath. These were located at the bottom of the wall with the door to the toilet area and the corner of the wall near the sink

The window in room 263 was observed to have paint peeling away exposing a weathered wood frame that was no longer functioned properly in that it could not be fully closed from the inside and locked.

LTCH Inspector #138 spoke with the Maintenance Coordinator who was able to demonstrate a preventative maintenance schedule and routine maintenance audits for

the home. The inspector then spoke with the Environmental Coordinator who stated that the Maintenance Coordinator has a preventative maintenance schedule including painting but that the schedule often gets interrupted to deal with urgent maintenance issues that arise. The Environmental Coordinator further stated that with respect to the uneven flooring in spa room on Bathurst, the home recognizes that it is a risk to residents and stated that the plan is to have the spa room completely renovated starting January 2015. As for the windows, The Environmental Manager stated that some windows in the home, located on the backside of the older wing of Wiseman and Ontario units, where the window for room 263 resides, are wooden frames that have deteriorated and require replacements as many of these windows can no longer be closed properly from the inside. She further stated that these windows must be closed from the outside and screwed shut in order close and lock the window. [s. 15. (2) (c)]

2. The Licensee failed to comply with section 15(2)(a) of the Act in that the Licensee failed to ensure the home, furnishings, and equipment are kept clean and sanitary.

On November 4, 2014, during Stage 1 of the RQI, it was observed by LTC Inspector #573 that Resident #027's wheelchair wheels and frame were unclean with a white splattered substance and stains that resembled old food. It was also observed that Resident #017 and #020's wheelchair had dried debris on the lower metal frame, brakes, and wheels and that Resident #020's lap belt was also stained with debris resembling dried food.

On November 10, 2014, during an interview with a PSW, Staff #132, who indicated to LTCH Inspector #573 that it is the responsibility of the PSWs on nights to clean resident wheelchairs and further stated that the resident wheelchair cleaning is done on a weekly basis as outlined by the cleaning schedule located at the nursing station.

On November 10, 2014, LTCH Inspector #573 spoke with Environmental Coordinator who stated that every resident wheelchair is cleaned on a weekly basis by the night PSWs. The Environmental Coordinator also indicated that resident wheelchairs are to be cleaned by the PSWs whenever they are observed to be unclean or dirty. The inspector observed the three identified wheelchairs noted above for Residents #017, #020, #027 in the presence of the Environmental Coordinator who agreed that the wheelchairs were unclean and further indicated that they should be kept clean. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance 1) to ensure that the tile flooring in the vestibule of the main entrance, the first floor lounge, and the spa room on the first floor Bathurst wing is repaired so that tiles are secured and the floor is even to prevent tripping hazards for residents and 2) to ensure that resident wheelchairs are kept clean as required, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with section 15(1)(b) of the regulation in that steps were not taken to prevent resident entrapment with bed rails, taking into consideration all potential zones of entrapment.

During the resident observation activity conducted at stage 1 of the RQI, it was noted by LTCH Inspectors #573 and #138 that there were several residents bed systems in which bed rails (also know as side rails) were in use where the spaces between upper and lower horizontal bars of a bed rail were large (this area is know as Zone 1 of a bed rail).

LTCH Inspector #573 reviewed the Health Canada document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", with an

effective date of 2008/03/17. This document indicates that Zone 1 is any open space within the perimeter of the rail. Health Canada identifies in the document that the dimensional limit for Zone 1 is no greater than 120 mm (4 ¾ inches).

LTCH Inspector #573 made the following observations for the identified resident's bed system on November 6, 2014:

In rooms 227-1, 214-2, 221-1, 244-1: two ¾ length bed rails measured 5 inches gap between the perimeter of upper and lower side rail horizontal bars (Zone 1).

On November 10, 2014, LTCH Inspector #573 spoke with the RAI/Education Coordinator and Maintenance Coordinator. Both reported that the home completed a bed system assessment for all bed systems in the home in 2011 which was done by an external consultant.

LTCH Inspector #573 reviewed the Bed Frame Assessment report 2011 by the external consultant noting that the report identified a dimension within the perimeter on the bed rails for Zone 1 that was consistent with the Health Canada document and should not be greater than 4 ¾ inches. Further, the report specifically indicated the above noted bed systems have no entrapment risk despite measurements more than 4 ¾ inches in Zone 1.

On November 10, 2014, LTCH Inspector #573 observed the four identified bed systems noted above in the presence of the RAI/Education Coordinator and Maintenance Coordinator. The Maintenance Coordinator, who stated was trained to test bed systems for entrapment, used the bed system measurement device of a cone and cylinder tool and assessed the identified bed systems. Each bed system was found to measure more than the recommended space for Zone 1 indicating a potential entrapment risk to residents.

On November 12, 2014, LTCH Inspector #573 again spoke with the home's Maintenance Coordinator who stated that no further steps since the bed assessment audit in 2011 have been taken to prevent resident entrapment as it relates to Zone 1 for the four bed systems identified above. LTCH Inspector #573 also observed that there were several rooms (243-2, 241-1, 249-1 and 2, 250-1, 211-1, 218-2 and 212-1) on the second floor that had the same style bed system in use.

LTCH Inspector #573 spoke with the Administrator on November 12, 2014 regarding the

identified concerns relating to the risk of entrapment in Zone 1 of the bed systems in use in the previously identified rooms. The Administrator stated that she is aware of the issue and mentioned that there are 32 similar bed systems in the home that would have the increased risk of potential entrapment in Zone 1 of the bed rail. The Administrator also stated that as an immediate measure the home is evaluating all such bed systems and steps will be taken by using a draping system to cover the entrapment zone. [s. 15. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the 32 older style bed systems that pose an increased risk for entrapment in Zone 1 of the bed rail are further assessed by the Licensee and steps are taken to reduce the risk of entrapment in Zone 1 of such bed rails, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that restraining of a resident by a physical device may be included in a resident's plan of care only if the restraining of the resident has been consented to by the residents, or if the resident is incapable, the substitute decision-maker (SDM) with authority to give that consent.

Resident #009 has a plan of care that provides direction under the heading of restraints for two bed rails up for safety. This plan of care also states under restraints that there

was no consent for the use of the bed rails. LTCH inspector #138 reviewed the resident's health care record and noted the physician's order for two bed rails up for personal safety but no documentation was found regarding consent for the bed rails. Staff #105, a second floor RPN, stated that consent for all restraints was obtained on a hard copy consent form filed on the resident's chart. The inspector was unable to find the consent on the resident's chart.

On November 10, 2014, LTCH Inspector spoke with a RN, Staff #125 regarding the consent for bed rail restraint for Resident #009. Staff #125 stated that the resident's SDM would have provided consent as the resident could not. She also stated that the consent would be documented on a form filed in the health record. The inspector explained that no form for consent could be found on the resident's health record and in response Staff #125 called the resident's SDM in the presence of the inspector and spoke with him/her regarding consent for bed rails. After the call, Staff #125 stated to the inspector that Resident #009's SDM stated to her that s/he was not given the opportunity to give consent for the use bed rails for Resident #009 and, further, does not wish for the use of bed rails. Staff #125 further stated that she arranged a meeting with Resident #009's SDM to further discuss the use of bed rails with the resident. [s. 31. (2) 5.]

2. Resident #020 was admitted to the home in 2010 and had a physician's order less than a year ago for two bed rails and front closing lap belt in the wheel chair as restraints. LTCH Inspector #573 reviewed Resident #020's current plan of care dated and noted under the heading of restraints that the resident is to use a front closing wheelchair lap belt and two 3/4 bed rails as physical restraints.

Resident #020's health care records were reviewed by LTCH Inspector #573 and the inspector was unable to locate any consent for the use of the two bed rails and front closing lap belt as a restraint.

On November 6, 2014, RN, Staff #103, reviewed the resident's health care record with LTCH Inspector #573 and confirmed that she could not find the signed consent form from Resident #020 or the SDM for the use of the two bed rails and front closing lap belt as a restraint. [s. 31. (2) 5.]

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 consent is obtained by the resident or SDM for the use of restraints, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that the Licensee responds in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

On November 7, 2014, LTCH Inspector #573 spoke with the past President and current member of the Family Council who indicated that the Licensee does not respond in writing within 10 days with regards to any advice related to the concerns or recommendations from the Family Council. The past President and current member of the Family Council further stated that the responses to the Family Council are usually done during the next Family Council meeting. Family Council meetings run monthly with a one month disruption over the summer. The minutes for the Family Council were reviewed from January 2014 to September 2014 and it was noted that there were concerns brought forward by the Family Council at the meetings but that the written responses by the home to the concerns were not provided until the following monthly Family Council meeting.

On November 7, 2014, LTCH Inspector #573 spoke with home's Administrator who confirmed that a written response with regards to concerns and recommendations to the Family Council was not given within 10 days. [s. 60. (2)]

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 Licensee responds to the concerns or recommendations made by the Family Council in writing within 10 days, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The Licensee failed to comply with section 85(3) of the Act in that the Licensee has failed to seek the advice of the Residents' Council in developing and carrying out of the annual satisfaction survey.

On November 6, 2014, LTCH Inspector #573 spoke with the Residents' Council President, who indicated that the Licensee did not discuss or seek the advice of the Residents' Council regarding developing and carrying out the annual satisfaction survey.

The inspector reviewed the minutes of the Residents' Council Meetings from January 2014 to October 2014 and this review indicated that the Residents' Council advice has not been requested in developing and carrying out the annual satisfaction survey. The inspector interviewed the Activity Coordinator, who is assigned to assist the Residents' Council, and she stated that the annual satisfaction survey is sent directly from the head office every year and further indicated that the home did not seek the advice of the Residents' Council in developing and carrying out this survey.

On November 7, 2014, LTCH Inspector #573 spoke with home's Administrator who stated that the home conducts an annual satisfaction survey every year but did not seek the advice of the Residents' Council in developing and carrying out the annual satisfaction survey. [s. 85. (3)]

2. On November 7, 2014, LTCH Inspector #573 spoke with the past President and current member of the Family Council who indicated that the Licensee did not seek any advice or input from the Family Council in developing and carrying out the annual satisfaction survey. The inspector also interviewed the Activity Coordinator who assists the Family Council and she stated that the Family Council had not been consulted with in developing and carrying out of the annual satisfaction survey.

On November 7, 2014, LTCH Inspector #573 spoke with home's Administrator who stated that the home conducts an annual satisfaction survey every year and confirmed that the home did not seek the advice of the Family Council in developing and carrying out this survey. [s. 85. (3)]

3. The Licensee has failed to comply with section 85(4)(a) of the Act in that the Licensee has failed to ensure that the results of the annual satisfaction survey are made available to the Family Council and to seek the advice of the Family Council in acting on the results.

On November 7, 2014, LTCH Inspector #573 spoke with the past President and current member of the Family Council who stated that the home did not share or make available the results of the annual satisfaction survey with the Family Council.

On November 7, 2014, LTCH Inspector #573 interviewed the Activity Coordinator who stated that the annual satisfaction survey results have not been shared with the Family Council nor did the home seek the advice from the Family Council in acting on its results.

On November 7, 2014, LTCH Inspector #573 spoke with home's Administrator who indicated that the home did not share the results of the annual satisfaction survey to the Family Council. [s. 85. (4) (a)]

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 Residents' Council and the Family Council have the opportunity to provide advice in developing and carrying out the survey, to be implemented voluntarily.

WN #8: 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).

Findings/Faits saillants :

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

On November 4, 2014, LTCH Inspector #573 observed in the second floor tub room of the Ontario wing a plastic basket containing: a used hair brush, 4 nail clippers, a used black comb, and nine used hair rollers. All items were not labelled.

On November 06, 2014, LTCH Inspector #117 observed in the second floor tub room of the Ontario wing a basket in the cupboard beside the main tub that contained 3 small nail clippers and 1 large nail clippers. These clippers were not labelled and appeared to have been used. There were other personal care items in the basket including an unlabelled and used brush and comb. Also observed in the second floor tub room of the Wiseman unit where 4 unlabelled nail clippers that were found on a shelf in the cupboard, several unlabelled and used hair brushes and combs as well as a cupboard drawer with several unlabelled and used hair rollers.

On November 6, 2014, the Administrator stated to LTCH Inspector #117, that the home does have a policy on cleaning, disinfection and sterilization of medical/nursing equipment and devices (Policy # NM-II-C060, effective since February 2009). The policy

does state that fingernail care equipment used on multiple residents or single use are to be cleaned and then disinfected with a high level disinfectant such as a peroxide based disinfectant, either Virox HLD 10 to be soaked for 10 minutes after each use, or with Gluterate solution for 20 minutes after each use. The policy also states that combs and brushes are to be clean with a R2A solution for 10 minutes weekly.

LTCH Inspector #117 spoke with unit RPN, Staff #105, and housekeeping staff member, Staff #136, regarding the labelling and cleaning of nail clippers and hair care tools. Both stated that it is the responsibility of the PSWs who give the residents their bath to ensure that the above identified items are cleaned and disinfected as per the home's policy. The RPN, Staff #105, stated that to her knowledge staff are to use a peroxide based disinfection solution which is a high level disinfectant and that this solution and articles being disinfected would be in the clean or soiled utility rooms. An examination of the second floor clean and soiled utility rooms was done by the inspector and the RPN. No peroxide based disinfection solution or articles being disinfected were found in either utility room.

LTCH Inspector #117 spoke with Staff #135 and Staff #137, both PSWs who do baths, as well as Staff #110, an RPN. The staff members stated that they use the tub/shower cleaning solution to clean and disinfect nail clippers. The inspector noted that the tub/shower cleaning solution is not a high level peroxide based disinfection solution. As for the hair tools, these staff were not aware of any process for cleaning the hair brushes, combs, or rollers that were in the tub/shower rooms. The staff members stated that residents' hairbrushes and combs should be labelled and not used if they are not labelled. When asked about the peroxide disinfectant, the staff members stated that this is usually kept in the clean utility room. An examination of the first floor clean utility room was done by the inspector and the two PSWs. No peroxide based disinfection solution or articles being disinfected were found.

The home's staff did not implement the home's infection prevention and control program as it relates to nail care equipment and hair care equipment such as brushes, combs and rollers. [s. 229. (4)]

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 participate in the implementation of the infection prevention and control program related to the cleaning and disinfecting of resident nail clippers, to be implemented voluntarily.

WN #9: 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).

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

Findings/Faits saillants :

1. The Licensee has failed to comply with section 3(1)11 of the Act by failing to ensure that the resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2003, kept confidential in accordance with that Act has been fully respected and promoted specifically as it relates to ensuring personal health information is kept confidential.

On November 3, 2014, it was observed by LTCH Inspector #117 that a RPN on the second floor, Staff #128, take a garbage bag containing several mediation packages that contained the resident name, room number, medication with dosages and prescribing physician on the medication packaging. It was observed that Staff #128 tied a knot in the garbage bag and place it in a general waste receptacle located beside the entrance to nursing office. Staff #128 indicated that she was informed by the Director Resident Care to destroy the medication packaging by ripping the medication package in half and putting it in the garbage.

On November 4, 2014, LTCH Inspector #548 observed a RPN on first floor, Staff #129, ripped open a medication package containing medication for Resident #061. The medication packaging contained the resident name, room number, medication with dosages and prescribing physician. Staff #129 poured the medications into the medication cup and threw the medication package into the garbage. Staff #129 stated that she disposes of the medication package by ripping them in half, placing them in the garbage, tying the bag and placing it in the soiled utility room. Staff #129 indicated that this is done every shift and that the garbage bag is placed with the general garbage and thrown out.

On November 10, 2014, discussion was held with the Director of Resident Care who stated that the procedure is to tear the medication package in half and then place it in the garbage bag. She indicated that the garbage bag is then brought downstairs for secure shredding.

On November 10, 2014, the Director of Resident Care provided to inspector the home's policy titled: The Medication Pass, policy # 3-6, dated 2014. The policy reads that medication packages can be destroyed with water to remove information and be placed into the garbage or shredded. The Director of Resident Care indicated that she was not aware that there had been a problem with storing the medication packages prior to their destruction as the company only came in every 6 months. The Director of Resident Care indicated if the staff informed the inspectors that they were throwing ripped medication packages with confidential information in the garbage then they must be doing so. The

Director of Resident Care indicated that she was unaware of this practice at the home. [s. 3. (1) 11. iv.]

WN #10: 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. The Licensee has failed to comply with section 8.(1)(a) of the regulation in that the Licensee failed to ensure that any required plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act.

In accordance with the section 114 (2) of the regulation, the Licensee shall ensure that written policies are developed for the medication management system. During a review of the home's medication management system on November 10, 2014, LTCH Inspector #548 reviewed the home's policy related to the documentation of monitored medications. The home has a policy titled: Individual Monitored Medication Record, Policy # 6-5, pages 1-3, dated 2014. The policy identifies the home's process for the documentation of monitored medications. The policy reads that each time a monitored medication is administered the date, time, amount given, amount wasted and new quantity remaining is to be documented.

The inspector reviewed the narcotic count records for three residents, Resident #057, #058 and #059. It was noted that each resident was administered a prescribed narcotic in the morning of November 10, 2014. It was noted that each administration was documented on the electronic Medication Administration Record. It was noted that for each individual resident there was no documentation on their individual Narcotic Record Sheet after the administration of the medication.

During an interview with a RPN, Staff #110, indicated that she administers all of the medication and then completes her documentation of monitored medications after her medication rounds are completed.

On November 10, 2014, during an interview with the Director of Resident Care, she indicated that she was not aware that documentation on the individual monitored medication record was not being done after the administration of such medication. The Director of Resident Care indicated that she expects documentation to be completed after administration of each monitored medication. [s. 8. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The Licensee failed to comply with section 24.(2) of the regulation in that the 24 hour admission care plan must identify the resident and must include, at a minimum, the following with respect to the resident: 1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. 2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. 3. The type and level of assistance required relating to activities of daily living. 4. Customary routines and comfort requirements. 5. Drugs and treatments required. 6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. 7. Skin condition, including interventions. 8. Diet orders, including food texture, fluid consistencies and food restrictions.

Resident #032 was admitted late in the year in 2013 with multiple diagnosis. The resident's health care was reviewed with the home's RAI/Educator Coordinator who confirmed that Resident #032 did not have a initial plan of care completed in accordance with section 24 (2) of the regulation. It was noted by LTCH Inspector #117 that the resident's initial plan of care, conducted on admission in 2103, only identified information related to nutritional status and activities and spirituality. This initial plan of care lacked information including risks, safety measures, type and level of assistance required for activities of daily living, customary routines, as well as drugs and treatments. [Log O-000765-14] [s. 24. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with section 27.(1) of the regulation in that the long-term care home did not ensure that, (a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; (b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and (c) a record is kept of the date, the participants and the results of the conferences.

Resident #032 was admitted to the home late in 2013. On November 10, 2014, LTCH Inspector #117 reviewed the resident's health care record with the home's RAI/Education Coordinator. No information related to the resident's six week post admission care conference was found. The RAI/Education Coordinator reviewed the home's resident care conference calendars and related tracking documents. The RAI/Education Coordinator confirmed that Resident #032 did not have a six week post admission care conference with the home's interdisciplinary care team to review with the resident and SDM the resident's care needs and plan of care. [Log O-000765-14] [s. 27. (1)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The Licensee has failed to comply with section 57.(2) of the Act in that the Licensee did not respond in writing within 10 days of receiving a concern or recommendation to the Residents' Council.

On November 6, 2014, during an interview, LTCH Inspector #573 spoke with the Residents' Council President who indicated that she was unsure if the Licensee responds in writing within 10 days to any concerns raised by the Residents' Council.

LTCH Inspector #573 reviewed the minutes of the Residents' Council Meetings from July to October 2014. It was observed by the inspector that the licensee responded in writing with regards to the concerns and recommendations from the Residents' Council but not within 10 days.

Specifically:
- For July 21, 2014, Residents' Council meeting regarding nursing/dietary concerns, the written response date was August 27, 2014.
- For August 18, 2014, Residents' Council meeting regarding administration concerns, the response date was September 5, 2014.
- For September 15, 2014, Resident Council meeting regarding tub room temperature concerns, the written response date October 7, 2014.
- For October 20, 2014, Residents' Council meeting regarding dietary concerns, the written response date was November 3, 2014 and the minutes posted on November 4, 2014.

LTCH Inspector #573 spoke with the Activity Coordinator who assists the Residents' Council and she stated that the written responses to the Residents' Council are not always within 10 days.

On November 7, 2014, LTCH Inspector #573 spoke with home's Administrator who confirmed that the written response with regards to concerns and recommendations raised by the Residents' Council was not given within 10 days. [s. 57. (2)]

WN #14: 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. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The Licensee failed to ensure that the every use of a physical device to restrain a resident under section 31 of the Act is documented and the licensee shall ensure that the following are documented (6) all assessment, reassessment and monitoring, including the resident's response.

Resident #009's current plan of care directs staff to use two bed rails as a restraint for safety. There is also a corresponding physician's order for the use of two bed rails in the up position for safety. LTCH Inspector #138 spoke to a PSW, Staff #131, regarding the documentation of the monitoring of restraints including bed rails and Staff #131 stated that the monitoring of all restraints is documented on a form kept in a binder on each of the units. The inspector proceeded to the resident's unit, located the appropriate binder but was unable to locate the form within the binder for the use of Resident #009's bed rails. The inspector then proceeded to speak with the unit RPN, Staff #105, regarding the documentation of the monitoring of restraints. Staff #105 stated that the monitoring of any restraint is documented on a form titled "Restraint and Personal Safety Device Monitoring Record" and is kept in a binder on each of the units. The inspector reported to Staff #105 that she was unable to find such a form for the use of Resident #009's bed rails. Staff #105 stated that the use of bed rails for Resident #009 is a restraint and that a monitoring form should be in place for the use of bed rails. Staff #105 then arranged to have the monitoring form in place for use of bed rails for Resident #009.

LTCH Inspector #138 spoke with the Director of Resident Care regarding the lack of documentation regarding the monitoring of the use of bed rails as a restraint for Resident #009. The Director of Resident Care stated that staff are required to monitor residents hourly, especially when residents are sleeping and bed rails are in the up position and acknowledged that the documentation of this monitoring is still required. [s. 110. (7) 6.]

Issued on this 18th day of November, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PAULA MACDONALD (138), ANANDRAJ NATARAJAN (573), LYNE DUCHESNE (117), RUZICA SUBOTIC-HOWELL (548)
Inspection No. / No de l'inspection :	2014_362138_0015
Log No. / Registre no:	O-001107-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 18, 2014
Licensee / Titulaire de permis :	DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC 2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	PERTH COMMUNITY CARE CENTRE 101 CHRISTIE LAKE ROAD, R. R. #4, PERTH, ON, K7H-3C6
	Susan Woodcock

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

Name of Administrator /
Nom de l'administratrice ou de l'administrateur :

To DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The Licensee shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15cm.

Grounds / Motifs :

1. The Licensee failed to comply with O. Reg 79/10 s. 16 in that the Licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 cm.

On November 3, 2014, during initial observations of resident rooms during Stage 1 of the Resident Quality Inspection, LTCH Inspector #548 observed windows on the first floor in resident rooms 160, 161, 162, and 163 to open more than 35 cm. It was also observed that two of these rooms, 160 and 162, did not have screens in place over the windows that opened.

LTCH Inspector #573 observed on the second floor in resident rooms 238, 240, 241, 243, 244, 249, 250 and 252 that there were sliding windows which can open on either side to an opening of 22 cm. It was also noted that these windows are equipped only with a half screen that was not sufficient to cover the possible opening on each side of the window.

On November 7, 2014, LTCH Inspector #573 spoke with the home's Maintenance Coordinator who stated that all the sliding windows on second floor will open 20 cm to 25 cm and are placed with half screens. The Maintenance Coordinator also stated to the inspector that he was aware that the windows accessible to residents on first floor open more than 15 cm.

On November 7, 2014, both the Maintenance Coordinator and Administrator indicated to LTCH Inspector #573, that they were unaware of the requirements of section 16 of the regulation. The Administrator further stated that she will arrange to make the necessary modifications to the windows within the next day or two.

On November 12, 2014, LTCH Inspector #138 observed while walking up to the home from the parking lot that morning that there was a window in a residential area opened more than the allowable amount of 15 cm. After entering the building, the inspector proceeded to the first floor Bathurst wing and located the opened window at the end of the residential hallway next to the E1 stairwell door. The window was located on the bottom left side of the end of the hallway and measured approximately two feet by two and a half feet in dimensions. The inspector noted that the window was opened approximately 25 cm and that it could be fully opened by using the window crank. The inspector noted that the ground outside the window was approximately four feet below. It was also noted that at the end of the grounds was a main road and railway tracks. LTCH Inspector #138 spoke with the Administrator regarding the opened window on Bathurst wing. The Administrator stated that she was under the belief that the Maintenance Coordinator had ensured all windows were modified so that they could not be opened more than the allowable amount.

LTCH Inspector #573 spoke with the Maintenance Coordinator on November 12, 2014 regarding the concerns related to windows in the resident rooms and common area which were opening more than 15 cm. The Maintenance Coordinator stated that, to-date, all the windows are not completely fixed and that he is currently working to do necessary modifications.
(573)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 03, 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.

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 18th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PAULA MACDONALD

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