Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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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
Feb 12, 2014	2014_198117_0002	O-000033-14	Complaint

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

LYNE DUCHESNE (117), MEGAN MACPHAIL (551)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 15, 16, 17 and 20, 2014

It is noted that two complaint inspections were conducted, log # O-000033-14 and log # O-001225-13

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), RAI Coordinator, Maintenance Manager, Office Administrator in charge of registered and non- registered nursing staff scheduling, Food Service Supervisor, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSWs), several dietary aides, several housekeeping aides and to several residents.

During the course of the inspection, the inspector(s) reviewed the health care records for several identified residents, observed resident care and services, observed the lunch time meal services of Janaury 15 and 16, 2014, observed the morning and afternoon beverage and snack passes for January 15 and 16, 2014, reviewed the home's meal and snack Winter/Spring menus, reviewed the home's January 2014 therapeutic meal spreadsheets and food temperature sheets, reviewed the 2nd floor unit PSW staff assignment sheets, examined mechanical lifts and slings, examined and activated the resident-staff communication response system in several resident rooms and toilet areas on the 1st and 2nd floor units, reviewed home's Wound Care policy #NM-II-W020, revised Feb 2009, reviewed the home's Zero Tolerance for Abuse and Neglect 2013 training records, reviewed the TENA program resident continence assessments for November 2014 and January 2014, reviewed the registered nursing and PSW staff work schedules dated December 29 2013 to January 11 2014, and reviewed the 1st and 2nd floor unit maintenance request logs from October 25 2013 to January 8 2014,

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Medication
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 90 (2) (b) in that procedures were not implemented to ensure that all equipment, devices and assistive aids and positioning aids in the home are kept in good repair.

1) Mechanical Lifts
On January 15, 2014 it was observed by Inspector #117 that the 2nd floor ARJO sit to stand lift had broken arm rests. The arm rests are made of dense foam. The right arm rest lower section is chipped and broken, with ragged edges and missing half of the elbow cup support. The left arm rest lower section is chipped away, leaving ragged edges, with no elbow cup support. The metal frame is visible. It was also noted that the up/down functions were not working even when the lift battery was turned on.

Staff member #109 stated that the ARJO sit to stand lift arm rests were replaced about 1 year ago. She stated to Inspector #117 on January 17, 2014, that the arm rests get damaged when the lift gets caught in resident wheelchairs during transfers. She is not aware if there has been a request to have the lift arm rests repaired.

On January 16, 2014, it was observed by Inspector #117 that the 1st floor white, metal sit to stand lift's hand held device for up/down does not work for the up position. As per interviewed staff member #113, the lift will function when the battery buttons for up/down is pressed. She stated that staff know not to use the hand held device as it has not been functional for a long period of time. Staff member #113 is not aware if the home's maintenance department is aware of the lift functional issues.

2) Resident-Staff Communication and Response System
The following issues were observed on January 15 and 16, 2014 by Inspectors #117 and # 551 in regards to the home's resident-staff communication and response system (the system):

• On the 1st floor unit, there were 4 working pagers for 6 PSWs working on the day

shift. On January 16, 2013, it was further noted that one of these 3 available pagers was not functioning properly, as it did not respond to system calls made from rooms # 141, #143, #121, #123, #111 and #119 when tested by the inspector.
• On the 2nd floor unit, there were only 3 working pagers for 7 PSWs working the day shift. On January 15, 2014, it was further noted that one of these page 3 available pagers was not functioning properly, as it did not respond to system calls made from rooms #216 and #218 when tested by the inspector.

On January 15 and 16, 2014, it was noted by Inspector #117 that several system consoles in resident bathrooms were in a poor state of repair on the 1st floor unit. Staff members #116 and #117 report that when activated, the system consoles can only be reset with a magnet. Each bathroom console has a magnet set into the pull cord.

• Bathroom # 138 console pull cord is cut short and is difficult to pull/activate. It is missing a magnet to reset the system console.
• Bathroom # 143 has loose magnet in the console pull cord. When the cord is pulled, the magnet falls to the floor.
• Bathroom #147 has loose magnet in the console pull cord. When the cord is pulled, the magnet falls to the floor.

Interviewed staff members #111, #112, and #114 stated to Inspector #117 that they are never sure if the system pagers that are currently working at the start of their shifts, will register activated calls. This means that staff do not know when residents are calling for assistance, creating delays in the provision of resident care.

Interviewed staff members stated that pager batteries are often non-working and require frequent replacement. They also stated that the pagers often break. They do report pager issues immediately to the home's Maintenance Manager who does try to fix the pagers, however they are often left with 1 pager for 2 – 3 staff members.

A review of the 1st and 2nd floor maintenance logs was done for the months of November, December 2013 and January 2014. There is no information found in the logs related to the either identified lifts requiring repairs, nor to the identified call bells requiring repairs.

Home Maintenance Manager stated to Inspector # 117 on January 15, 2014 that he

was not aware of any issues neither with the two identified lifts nor with the resident-staff communication and response system toilet consoles and cords. He stated that it is the staff's responsibility to report any damaged or non-functioning equipment, including system console/cord issues, to the maintenance department. The home does have a maintenance log on each unit, which is verified daily. Any issues with lifts are to be promptly identified and the lifts tagged and removed from the units until they are repaired.

In regards to the home's resident-staff communication and response system, the Maintenance Manager stated to Inspector #117 that for the past 2-3 weeks there have been ongoing maintenance issues with the system pagers. There were 8 pagers that required maintenance in the past 2 weeks. Four have been repaired and the other four are non-functioning and need to be replaced. There are no other functioning pagers that can be given to nursing staff.

On January 17, 2014, the home's Administrator did confirm that there have been ongoing issues with the number and availability of functioning pagers for PSW staff in the past 2-3 weeks. She indicated that the home's management and maintenance department are in contact with the system service provider to get new system pagers to ensure that each working PSW has a functioning pager. However, at this time there are not enough available pagers for the number of staff working on the resident care units

It is noted that there are multiple issues with the home's resident-staff communication and response system related to accessibility of the system at 2 toilets, the availability of functioning system pagers for PSW staff and ongoing repair issues with the same system pagers. On February 25, 2013, during Inspection # 2013-197103-009, a Compliance Order #003 related to the accessibility of the home's resident-staff communication and response system was issued. Although the Compliance Order was found to be in compliance during an inspection conducted on July 11, 2013, the above identified issues pose a widespread risk to residents as there is the potential/actual risk that PSW staff is not made aware of resident care needs due to system issues. Therefore a Compliance Order will be issued. [s. 90. (2) (b)]

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O.2007, c. 8, s. 6 (1) (a) in that the written plan of care for a resident does not set out the planned care for a resident.

Resident #1 is identified as being incontinent of bladder and bowels. The plan of care indicates that the resident is to be toileted every 2 hrs and as needed, that staff are to ensure that perineal care is done and that the resident is kept dry and clean. Staff members #107 and #108 report that Resident #1 frequently develops skin redness and excoriation in the groin and perineum areas. They are to apply two types of topical creams to help protect and heal the reddened skin. It was noted that the resident does have two types of topical cream at his/her bedside. This information was confirmed by unit registered staff members # 103, # 105 and #115 on January 16 and 17 2014. The registered staff report that the resident does have ongoing skin redness and occasional excoriation in the groin and perineal regions. Any concerns related to

the resident's skin integrity are reported to them by the attending PSWs, for further assessment and interventions.

The resident's plan of care, in effect at the time of the inspection, does not identify Resident #1's ongoing skin redness, occasional excoriation and the use of two types of topical creams as interventions for maintaining the resident's skin integrity. [s. 6. (1) (a)]

2. The licensee failed to comply with LTCHA 2007, c.8, s. 6 (11) (b) in that a resident's continence needs were not reassessed and the plan of care reviewed and revised because the care set out in the plan has not been effective.

Resident #4's continence care products were assessed by the home's TENA continence care team in November 2013. The TENA team used the TENA Products - "Quick Reference Guide: A resident-centric Approach to Individualized Product Selection" to determine which continence products would best met the resident's needs. It was determined that Resident #4 would best be served with comfort day plus liners which are a bit shorter then previous products used but with the same absorbency and elastics to contain micturition. For night time needs, Resident #4 was assessed to have an identical night liner which is longer and with elastics. Since a specific dated in December 2013, Resident #4 has been using these new continence products.

On January 16, 2014, during the inspection, it was reported by staff member #105 to Inspector #117, that Resident #4 was seated in his/her wheelchair, with wet clothing and a puddle of urine under his/her wheelchair. PSW staff were requested to assist to clean and change the resident. As per staff member #105, this was not the first instance in which the resident's new continence products overflow. The staff member indicated that the continence products have not been reassessed since December 2013 when the new product use was implemented. Staff member #105 is not aware if the home's TENA team has been informed of the ongoing overflow issues with the resident's new continence products

Staff member #109 stated to Inspector #117 on January 16, 2013, that Resident #4's continence products regularly overflow during the day and on nights. As per staff member #109, this rarely occurred prior to December 2013 change in TENA products. Staff member #109 stated that several instances of urine overflow have been reported to the unit registered staff since the change to the new TENA products. The staff

member is not aware of any product reassessment being done for Resident #4's continence needs.

Discussion held on January 17, 2014 with the home's RAI Coordinator and TENA continence team lead. She states that she and other TENA team members are not aware that there were issues with Resident #4 and continence product urine overflow. The RAI coordinator states that registered nursing staff did receive directions in early December, 2013 to reassess residents continence needs should there be an issue with the new continence care products. She states that staff are to use a product/voiding diary to reassess resident continence needs.

A review of the resident #4's health care record for December 2013 and January 2014 indicates that although the resident is regularly toileted, the resident has had two episodes in which continence overflow was noted, on a specific date in December 2013 and in January 2014. No information was noted in the resident's health care record related to unit nursing staff initiating a reassessment of the resident's continence products.

The home's registered staff did not reassess Resident #4's continence care needs when issues with continence product overflow were reported and observed on a specified day in December 2013 and on two specified days in January 2014. Care plan interventions related to the resident's continence needs were not reassessed to meet Resident #4's continence needs. [s. 6. (11) (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 that residents plan of care identify all of the residents actual and potential skin integrity issues and interventions, including those related to toileting, as well as to ensure that residents continence management plan of care is reviewed and reassessed when there is a change in the residents continence needs,, to be implemented voluntarily.

WN #3: 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 failed to comply with O.Reg. 79/10, s. 8 (1) in that 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, (b) is complied with.

Under O.Reg 79/10 s. 48 (1) (2) for required programs, the home is to have a skin and wound care program. The home does have such a program. The policy for Wound Care # NM-II-W020, dated February 2009, stated on page 2 that staff must "Obtain consent related to the treatment plan from the resident or his/her legally designated SDM".

On a specified day in January 2014, staff member #106 reported to staff member #103 that Resident #1 was presenting with red excoriated perineal skin with the presence of skin breakdown. Chart documentation indicates that since a specific date in December 2013, the resident had been presenting with reddened skin and some skin excoriation to the groins. Skin care interventions, including the application of two topical creams were implemented. On two consecutive days in January, nursing reports indicate that areas of skin breakdown were now present on the resident's perineal skin.

Staff member #103 stated to Inspector #117 on January 16, 2014, that she consulted with the home's RAI Coordinator as to the tracking/ measuring of Resident #1's skin breakdown. The staff member stated that directions were given to use the home's new electronic Wound Tracking system. The Wound Tracking system includes the ability for taking digital pictures of resident skin breakdown to track wound healing progress.

As per staff member #103, she took the specialized digital camera, and went with staff

member #104 to the tub /shower room in which Resident #1 was just finishing a bath with staff member #106. Resident #1 was seated in the tub chair, fully covered but without continence products. Staff member #106 left the tub room. Staff members #103 and #104 each took a picture of Resident #1's perineal skin breakdown. Staff member #103 stated that she had not spoken with either of Resident #1's Power of Attorney (POA) to advise them of the resident's skin condition and request to take pictures of the resident's skin as part of the home's treatment interventions. The staff member stated that one of the resident's POA was at the home at the time of the incident. Staff member #103 confirmed that she did not communicate with the POA regarding the resident's skin issues or seek consent from the POA to take pictures of the resident's perineal wounds on a specific day in January 2014.

Resident #3 sustained a wound to an arm on a specified day in May 2013. The resident has been receiving ongoing wound care treatments and dressings 2-3 times per week since that specified day in May 2013. It was noted that several pictures were taken of Resident #3's wound and had been tracked on the home's electronic Wound Tracker system. It is noted that Resident #3 was interviewed by Inspector #117 on January 16, 2014 and could not recall giving consent for pictures to be taken of his/her wound. No documentation was found in the resident's health care record related to the taking of wound pictures. Interviewed staff members #103 and #105 stated to Inspector #117 on January 16, 2014, that they do not recall informing and seeking consent from Resident #3's POA for taking pictures of the resident's wound as part of the wound treatments and interventions. No documentation was found in the resident's chart related to this specific treatment intervention consent.

Discussion held on January 16, 2014 with the home's Administrator and Director of care, as well as with the home's RAI Coordinator on January 17, 2014. All three stated that the home's skin and wound care policy is specific in that consent needs to be obtained from the resident or his/her legal substitute decision maker (SDM) in regards to any skin/wound care interventions and/or treatments. Digital pictures are part of the skin/wound treatment interventions. Therefore consent needs to be obtained prior to taking any pictures of resident skin/wounds.

Nursing staff did not follow the home's Skin Wound policy. They did not obtain Resident #1, Resident #3 or their legal SDMs consent to take pictures of skin breakdown / wounds as part of their skin and wound care treatment interventions. [s. 8. (1)]

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 registered nursing staff get consent from the capable resident or their legal substitute decision maker (SDM), in regards to skin/wound treatments and interventions as per the home's policy, including digital wound tracking photographs, and ensure that the consents are documented in the residents chart, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s. 17 (1) (d) in that the home is not equipped with a resident-staff communication and response system that is available at each bed, toilet, bath and shower location used by residents.

On January 15 and 16, 2014, it was noted by Inspector #117 that two bathroom resident-staff communication and response systems (the system) were not functioning on the 2nd floor unit.

• The system in bathroom # 216 self-cancels immediately after it is and therefore does not produce a call for assistance when the cord attached to the wall console next to the toilet is pulled.
• Although system hardware is in place, the system is not available for use at the toilet #209. It is not being registered on staff pager held when it was activated.

Home Maintenance Manager stated to Inspector # 117 on January 15, 2014 that the home does have a computer system that verifies the home's resident-staff communication and response system every morning. He states that when any issues with the system are identified, this becomes a priority for repairs. The Manager stated to inspectors #117 and #551 on January 17 that he was not aware of any system issues with the two identified system toilet consoles and that these would be immediately verified. [s. 17. (1) (d)]

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 toilet is equipped with a resident-staff communication and response system, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 44 in that home did not ensure that supplies, equipment and devices related to the home's resident-staff communication and response system is readily available at the home to meet the nursing and personal care needs of residents.

The home's communication and response system (the system) uses pagers to notify staff when residents the system is activated. There is no sound or light at the resident bed or room door to identify when the system is activated. As per the home's Administrator and Maintenance Manager, each working PSW is to have and carry a pager at all times to identify and respond to resident care needs. The unit RN and RPN also have pagers that are activated 5 minutes after a call bell is activated and not responded to by PSW staff.

On January 15, 2014, the Maintenance Manager stated to Inspector #117 that for the past 2-3 weeks there have been ongoing maintenance issues with the system pagers. There were 8 pagers that required maintenance in the past 2 weeks.

On January 17, 2014, the home's Administrator did confirm that there have been ongoing issues with the number and availability of functioning pagers for PSW staff in the past 2-3 weeks. She indicated that the home's management and maintenance department are in contact with the system service provider to get new system pagers to ensure that each working PSW has a functioning pager. However, at this time there are not enough available system pagers for the number of staff working on the resident care units. [s. 44.]

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 is are enough resident-staff communication and response system pagers, one for each working PSW, that is readily available to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. On January 15, 2014 Inspector 551 arrived on the second floor at approx 10:35 and observed a prepared nourishment cart in the inner dining room. A Food Service Manager indicated that nourishment times on the second floor are at 10:30, 14:30 and 18:30.

At 11:33 the nourishment cart remained in the inner dining room and had not been circulated to the residents. A resident's family member, who is the President of the home's Family Council, was observed to come and get a cup of tea for their loved one. The family member stated to Inspector #551 that the beverage cart had not been circulated that morning. As such residents were not offered a between meal beverage in the morning of January 15, 2014. [s. 71. (3) (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 that the morning beverage passes are done as per the home's dietary schedule, to be implemented voluntarily.

Issued on this 13th day of February, 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNE DUCHESNE (117), MEGAN MACPHAIL (551)
Inspection No. / No de l'inspection :	2014_198117_0002
Log No. / Registre no:	O-000033-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 12, 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
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Woodcock

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. 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;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee is to ensure that all of the home's mechanical lift equipment is assessed, repaired and then regularly inspected to ensure that mechanical lifts are kept in good repair.

The licensee is to ensure that the following actions are done in regards to the home's resident-staff communication and response system :
- that there be a process to identify when there are system issues and non-functioning consoles
- that there be a process to ensure that the system, consoles, pull cords magnets are repaired in a timely manner
- that there be enough functioning system pagers to ensure that each working PSW has a functional system pager to be able to respond to resident care needs

Grounds / Motifs :

1. The licensee failed to comply with O.Reg. 79/10, s. 90 (2) (b) in that procedures were not implemented to ensure that all equipment, devices and assistive aids and positioning aids in the home are kept in good repair.

1) Mechanical Lifts
On January 15, 2014 it was observed by Inspector #117 that the 2nd floor ARJO sit to stand lift had broken arm rests. The arm rests are made of dense foam. The right arm rest lower section is chipped and broken, with ragged edges and missing half of the elbow cup support. The left arm rest lower section is chipped away, leaving ragged edges, with no elbow cup support. The metal frame is visible. It was also noted that the up/down functions were not working even when the lift battery was turned on.

Staff member #109 stated that the ARJO sit to stand lift arm rests were replaced about 1 year ago. She stated to Inspector #117 on January 17, 2014, that the arm rests get damaged when the lift gets caught in resident wheelchairs during transfers. She is not aware if there has been a request to have the lift arm rests repaired.

On January 16, 2014, it was observed by Inspector #117 that the 1st floor white, metal sit to stand lift's hand held device for up/down does not work for the up position. As per interviewed staff member #113, the lift will function when the battery buttons for up/down is pressed. She stated that staff know not to use the hand held device as it has not been functional for a long period of time. Staff member #113 is not aware if the home's maintenance department is aware of

the lift functional issues.

2) Resident-Staff Communication and Response System
The following issues were observed on January 15 and 16, 2014 by Inspectors #117 and # 551 in regards to the home's resident-staff communication and response system (the system):

• On the 1st floor unit, there were 4 working pagers for 6 PSWs working on the day shift. On January 16, 2013, it was further noted that one of these 3 available pagers was not functioning properly, as it did not respond to system calls made from rooms # 141, #143, #121, #123, #111 and #119 when tested by the inspector.
• On the 2nd floor unit, there were only 3 working pagers for 7 PSWs working the day shift. On January 15, 2014, it was further noted that one of these page 3 available pagers was not functioning properly, as it did not respond to system calls made from rooms #216 and #218 when tested by the inspector.

On January 15 and 16, 2014, it was noted by Inspector #117 that several system consoles in resident bathrooms were in a poor state of repair on the 1st floor unit. Staff members #116 and #117 report that when activated, the system consoles can only be reset with a magnet. Each bathroom console has a magnet set into the pull cord.

• Bathroom # 138 console pull cord is cut short and is difficult to pull/activate. It is missing a magnet to reset the system console.
• Bathroom # 143 has loose magnet in the console pull cord. When the cord is pulled, the magnet falls to the floor.
• Bathroom #147 has loose magnet in the console pull cord. When the cord is pulled, the magnet falls to the floor.

Interviewed staff members # #111, #112, and #114 stated to Inspector #117 that they are never sure if the system pagers that are currently working at the start of their shifts, will register activated calls. This means that staff do not know when residents are calling for assistance, creating delays in the provision of resident care.

Interviewed staff members stated that pager batteries are often non-working and require frequent replacement. They also stated that the pagers often break.

They do report pager issues immediately to the home's Maintenance Manager who does try to fix the pagers, however they are often left with 1 pager for 2 – 3 staff members.

A review of the 1st and 2nd floor maintenance logs was done for the months of November, December 2013 and January 2014. There is no information found in the logs related to the either identified lifts requiring repairs, nor to the identified call bells requiring repairs.

Home Maintenance Manager stated to Inspector # 117 on January 15, 2014 that he was not aware of any issues neither with the two identified lifts nor with the resident-staff communication and response system toilet consoles and cords. He stated that it is the staff's responsibility to report any damaged or non-functioning equipment, including system console/cord issues, to the maintenance department. The home does have a maintenance log on each unit, which is verified daily. Any issues with lifts are to be promptly identified and the lifts tagged and removed from the units until they are repaired.

In regards to the home's resident-staff communication and response system, the Maintenance Manager stated to Inspector #117 that for the past 2-3 weeks there have been ongoing maintenance issues with the system pagers. There were 8 pagers that required maintenance in the past 2 weeks. Four have been repaired and the other four are non-functioning and need to be replaced. There are no other functioning pagers that can be given to nursing staff.

On January 17, 2014, the home's Administrator did confirm that there have been ongoing issues with the number and availability of functioning pagers for PSW staff in the past 2-3 weeks. She indicated that the home's management and maintenance department are in contact with the system service provider to get new system pagers to ensure that each working PSW has a functioning pager. However, at this time there are not enough available pagers for the number of staff working on the resident care units

It is noted that there are multiple issues with the home's resident-staff communication and response system related to accessibility of the system at 2 toilets, the availability of functioning system pagers for PSW staff and ongoing repair issues with the same system pagers. On February 25, 2013, during Inspection # 2013-197103-009, a Compliance Order #003 related to the

accessibility of the home's resident-staff communication and response system was issued. Although the Compliance Order was found to be in compliance during an inspection conducted on July 11, 2013, the above identified issues pose a widespread risk to residents as there is the potential/actual risk that PSW staff is not made aware of resident care needs due to system issues. Therefore a Compliance Order will be issued.

(117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 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 12th day of February, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNE DUCHESNE

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