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
Mar 6, 2014	2014_217137_0007	L-000191-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ELGIN MUNICIPAL HOMES
475 Talbot Street E., AYLMER, ON, N5H-3A5

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

TERRACE LODGE
475 TALBOT STREET EAST, 49462 TALBOT LINE, AYLMER, ON, N5H-3A5

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

MARIAN MACDONALD (137), MELANIE NORTHEY (563), RHONDA KUKOLY (213), RUTHANNE LOBB (514)

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): February 24-27, 2014

During the course of the inspection, the inspector(s) spoke with Director of Seniors Services, Manager of Resident Care, Director of Support Services, Manager of Programs and Therapy, Consultant Pharmacist, Building Maintenance Manager, Resident Assessment Instrument Coordinator (RAI), Registered Dietitian, Resident Care Coordinator, 2 Registered Nurses, 7 Registered Practical Nurses, 11 Personal Support Workers/Health Care Aides, 5 Housekeepers, 1 Recreation Assistant, 1 Dietary Aide, 40+ Residents and 3 Family Members.

During the course of the inspection, the inspector(s) conducted a tour of all resident home areas and common areas, medication room, laundry room, observed resident care provision, resident-staff interactions, dining service, recreational activities, medication administration, medication storage areas, reviewed relevant residents' clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents as evidenced by:

a) During the initial tour on February 24, 2014, Inspectors # 213 and # 563 observed the stairwell, connecting the ground and second floors, to be open. The opening was measured at 60 inches wide. At the top, there are two metal posts secured to the floor, 20 inches apart. The stairwell is near the elevator where residents are transported to and from the dining room.

The opening poses a potential fall risk to residents who may try to access the stairs.

b) Inspectors # 137 and # 514 observed a housekeeping cart to be locked but unattended on the basement level, in a location accessible to residents. Two containers of disinfectant and one container of toilet bowl cleaner were observed on top of the cart.
The Director of Seniors Services shared the home's expectation is that the housekeeping cart should not be left unattended and chemicals kept inaccessible to residents.

c) Inspectors # 514 and # 563 observed a maintenance cart to be locked but unattended inside Upper South Home Area, near a tub room. Power tools, spray chemicals, batteries, electrical cords, bolts and screws were observed on the top of the cart.
Later the same day, all four inspectors observed the maintenance cart to be locked but unattended on the basement level, in a location accessible to residents. Power tools, spray chemicals, batteries, electrical cords, bolts and screws were observed on the top of the cart.
The Building Maintenance Manager and Director of Seniors Services shared the home's expectation is that the maintenance cart should not be left unattended and tools, etc. kept inaccessible to residents. [s. 5.]

2. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents as evidenced by:

a) A staff interview with the Manager of Support Services revealed there is no resident-staff communication and response system in the dining room and in the Malahide lounge adjacent to the dining room.

b) A staff interview with the Manager of Support Services revealed if a resident was unattended in the dining room or in the Malahide lounge, adjacent to the dining room, and was in distress, the resident would have no way of summoning for assistance.

c) An observation of the dining room and adjacent Malahide resident lounge revealed there is no resident-staff communication and response system available to the residents. [s. 5.]

3. The licensee has failed to ensure that all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door, as evidenced by:

An audit of residents rooms was completed on February 25, 2014.
On Lower North wing, 15/15 (100%) residents rooms have doors leading to the outside of the home, that are locked with a key lock.
On Lower South wing, 14/15 (93.3%) resident rooms have doors leading to the outside of the home, that are closed with a push button lock and are able to be opened by residents.
On Upper North wing, 15/15 (100%) resident rooms have doors leading to an outside balcony, that are closed with a push button lock and are able to be opened by residents.
On Upper South wing, 14/15 (93.3%) resident rooms have doors leading to an outside balcony, that are closed with a push button lock and are able to be opened by residents.

43/60 (72%) of all resident rooms have doors leading to the outside of the home that are able to be opened by residents.
60/60 (100%) of all resident rooms have doors leading to the outside of the home that are not equipped with a door access control system that is kept on at all times, and equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. [s. 5.]

4. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres, as evidenced by:

Audits of the resident rooms were completed on February 25, 2014.
In the Lower North wing, 6/15 (40%) resident rooms had one or more windows able to be opened greater than 15 cm.
In the Lower South wing, 13/15 (87%) resident rooms had one or more windows able to be opened greater than 15 cm.
In the Upper North wing, 15/15 (100%) resident rooms had one or more windows able to be opened greater than 15 cm.
In the Upper South wing, 13/15 (87%) resident rooms had one or more windows able to be opened greater than 15 cm.

78% of all resident rooms in the home have one or more windows able to be opened greater than 15 cm.

The Director of Seniors Services and the Manager of Resident Care confirmed that the windows could be opened more than 15 centimetres. [s. 5.]

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted; every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs as evidenced by:

a) An observation of three medication administrations, by inspector #137 and #563, revealed the clear medication strip packages were discarded by registered nursing staff in general garbage. The strip packages contained personal health information and was not altered in any way prior to disposal, to protect the resident's identity.

b) A staff interview with a Registered Staff Member revealed empty strip packages are disposed of in the general garbage receptacle, at the side of the medication cart, and then taken to the dumpster without deliberate alteration to protect resident personal health information.

c) A record review of "3-6 The Medication Pass Policy" states, "Empty strip pouches can be destroyed with water to remove information and placed into the garbage or shredded (PIPEDA)" and registered nursing staff are not following this policy.

d) A staff interview with the Consultant Pharmacist confirmed the home's expectation is for registered nursing staff to destroy the clear strip packaging with water, or tear the resident's name from the strip pack prior to discard, or blacken the resident's name on the packaging or the packaging is to be shredded. None of the above options, to protect the residents' identity, were implemented by the registered nursing staff.

e) An observation of the medication cart in a common area revealed the registered practical nurse did not afford the residents' privacy in treatment, by leaving the electronic medication administration records open and visible on the screen, while the medication cart was left unattended. Personal health information was readily accessible. [s. 3. (1) 8.]

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 every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

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Findings/Faits saillants :

1. The licensee has failed to ensure that a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, the restraining of the resident has been consented to by the resident or, if incapable, a substitute decision-maker of the resident with authority to give that consent, and the resident is monitored while restrained, in accordance with the requirements provided for in the regulations as evidenced by:

a) Resident #3412 was observed to have a front-fastening seat belt in place, while sitting in a wheelchair and was not able to undo the seat belt independently.
There was no physician's order for the seat belt restraint, no consent for the seat belt restraint and there was no documentation of monitoring of the restraint.
A wheelchair seat belt restraint was identified as a restraint in this resident's MDS Assessment and in a Restraint Assessment.
The Manager of Resident Care confirmed that this seat belt is a restraint and that there should be a physician's order, consent and it should be monitored every hour and documented.

b) Resident #3398 was observed to have a back-fastening wheelchair tray table in place, while sitting in a wheelchair and was not able to undo the tray table independently. There was no physician's order for the tray table restraint, no consent for the restraint and no documentation of monitoring of the restraint.
The wheelchair tray table restraint was not identified in this resident's plan of care.
The Manager of Resident Care confirmed that this tray table is a restraint and that there should be a physician's order, consent, identified in the plan of care, monitored

every hour and documented.

c) Resident #3450 was observed to have a front-fastening seat belt and a back-fastening wheelchair tray table in place, while sitting in a wheelchair and was not able to undo the seat belt or tray table independently.
A wheelchair seat belt restraint and wheelchair tray table were identified as restraints in this resident's plan of care.
There was no physician's order for the seat belt restraint and no consent for the seat belt restraint.
A Registered Practical Nurse confirmed that this seat belt is a restraint and that there should be a physician's order, consent, be monitored every hour and documented.

d) Resident #3473 was observed to have a back-fastening wheelchair tray table in place, while sitting in a wheelchair and was not able to undo the tray table independently.
A wheelchair tray table restraint was identified as a restraint in this resident's plan of care.
There was no physician's order for the tray table restraint.
The Manager of Resident Care confirmed that this tray table is a restraint and that there should be a physician's order.

e) Resident #1000 was observed to have a back fastening wheelchair tray table in place, while sitting in a wheelchair and was not able to undo the tray table independently.
A wheelchair tray table restraint was identified as a restraint in this resident's plan of care.
There was no consent for the tray table restraint.
The Manager of Resident Care confirmed that this tray table is a restraint and that there should be consent. [s. 31.]

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 a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, the restraining of the resident has been consented to by the resident or, if incapable, a substitute decision-maker of the resident with authority to give that consent, and the resident is monitored while restrained, in accordance with the requirements provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff as evidenced by:

a) The Resident Assessment Instrument Coordinator and two Registered Practical Nurses confirmed that weekly wound assessments are not being consistently completed and documented by registered nursing staff.

b) The Manager of Resident Care confirmed that it is the home's expectation that residents that have wound treatments, should have weekly assessment and documentation on the nursing progress notes. The Manager of Resident Care confirmed that there were no home documentation guidelines for the registered staff, documenting weekly wound assessments. [s. 50. (2) (b) (iv)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use as evidenced by:

a) Inspector # 137 observed door to Lower North nursing station room unlocked and witnessed by Inspector # 213. There was no registered staff in the vicinity. An unlocked cupboard, containing 1 bottle of Acetaminophen, 1 bottle of KCL 600 mg tablets, 3 bottles of rubbing alcohol, 1 bottle of Ferrous Gluconate, 3 jars of prescription creams and 3 containers of medicated shampoo was observed.

b) When the Registered Staff Member returned to the nursing station room. Inspector # 137 shared that the door was open, with 12 residents seated in the nearby adjacent lounge area. The Registered Staff Member shared that the door had been locked exiting the room and the expectation is that the door is to be locked at all times when staff are not in the room.

c) Inspector # 137 reported incident to Manager of Resident Care and it was confirmed the expectation is that the door is to be locked at all times when staff are not in the room. [s. 130. 1.]

2. The licensee failed to ensure all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home as evidenced by:

a) Inspector #137 observed Lower North nursing station room has stock medications accessible to Personal Support Workers (PSW's), housekeeping staff, as well as recreation staff.

b) Inspector #563 observed a Personal Support Worker (PSW) documenting, in Point of Care, in Lower North nursing station, without registered nursing staff present.

c) A staff interview with the Manager of Resident Care confirmed the nursing station on Lower North should be locked and access to stock medications by registered nursing staff only. [s. 130. 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 all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #6: 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. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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 the Infection Prevention and Control Interdisciplinary team meets at least quarterly as evidenced by:

a) The Manager of Resident Care confirmed that there were only two Infection Prevention and Control Interdisciplinary team meetings in 2013 (June and October) and that the home's expectation is that Infection Prevention and Control meetings occur quarterly. [s. 229. (2) (b)]

2. The licensee has failed to ensure that there is a written record of the annual Infection Prevention and Control program evaluation kept that includes the date of the evaluation, the names of the persons who participated and a summary of the changes made, and the date those changes were implemented, as evidenced by:

a) The Manager of Resident Care confirmed that the home had not completed an annual Infection Prevention and Control program evaluation prior to February 2014.

b) The Manager of Resident Care confirmed that the written record of the annual Infection Prevention and Control program evaluation did not include the date of the evaluation and the names of the persons who participated in the program evaluation. [s. 229. (2) (e)]

3. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program as evidenced by:

a) A registered staff member was observed wiping a resident's nose, during medication administration in the dining room, and did not follow up with hand hygiene between residents.

b) A registered staff member was observed wiping a resident's mouth, after assisting with a puffer treatment, and not following up with hand hygiene between residents.

c) It was observed that there were unlabeled nail clippers and unlabeled nail files in a common container in the supply cabinet of a tub room.

d) A Personal Support Worker was observed exiting an identified resident room and then answering the call bell in another identified resident room, without using hand sanitizer between care provision. The Manager of Resident Care confirmed that the home's expectation is that staff utilize hand hygiene procedures when providing care between residents.

e) During medication administration in the dining room, a registered staff member was observed not utilizing hand hygiene procedures between residents during medication administration of crushed medications, nasal sprays, and puffers.

f) It was observed that there were unlabeled containers of zinc, deodorant spray and hand/body lotion in the shared washroom of two identified resident rooms.. [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 the Infection Prevention and Control Interdisciplinary team meets at least quarterly, that there is a written record of the annual Infection Prevention and Control program evaluation kept that includes the date of the evaluation, the names of the persons who participated and a summary of the changes made, and the date those changes were implemented and that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the call bell communication system is maintained in a safe condition and in a good state of repair as evidenced by:

a) A bathroom observation for resident # 3372 and # 3467, in an identified resident room, revealed a non functioning call bell in a shared resident bathroom. The call bell cord could not be pulled as the pull cord was disconnected from main pull activation lever.

b) A bathroom observation for resident # 3388 and # 3389, in an identified resident room, revealed a non functioning call bell where the pull cord was not within reach and was hanging disconnected, over call bell panel.

c) Management confirmed that the bathroom call bell cords, in two identified resident rooms, were not connected and staff could not be alerted. [s. 15. (2) (c)]

Issued on this 6th day of March, 2014

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

Marian C. Mac Donald

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) :	MARIAN MACDONALD (137), MELANIE NORTHEY (563), RHONDA KUKOLY (213), RUTHANNE LOBB (514)
Inspection No. / No de l'inspection :	2014_217137_0007
Log No. / Registre no:	L-000191-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 6, 2014
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF ELGIN MUNICIPAL HOMES 475 Talbot Street E., AYLMER, ON, N5H-3A5
LTC Home / Foyer de SLD :	TERRACE LODGE 475 TALBOT STREET EAST, 49462 TALBOT LINE, AYLMER, ON, N5H-3A5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	RHONDA ROBERTS

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To THE CORPORATION OF THE COUNTY OF ELGIN MUNICIPAL HOMES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must take immediate action to achieve compliance by:
(a) installing a resident - staff communication and response system that is available in every area, including the areas identified in the grounds for the order.
(b) ensuring the opening to the hallway stairwell is secured to prevent resident access to the stairwell.
(c) ensuring maintenance and housekeeping carts are not left unattended, with chemicals, tools, etc., left on top of the carts.
(d) ensuring every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.
(e) ensuring that all doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be
i. kept closed and locked
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, S.O. 2007, c.8, s.5 to ensure that the home is a safe and secure environment for its residents.
The plan must include what immediate and long-term actions will be undertaken to correct the identified deficiencies, as well as identify who will be responsible to correct the deficiencies and the dates for completion.

Please submit the plan, in writing, to Marian C. Mac Donald, Long-Term care homes Nursing Inspector, Ministry of Health and Long Term care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2, by email, at Marian.C.Macdonald@ontario.ca by March 21, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents as evidenced by:

a) A staff interview with the Manager of Support Services revealed there is no resident-staff communication and response system in the dining room and in the Malahide lounge, adjacent to the dining room.
b) A staff interview with Manager of Support Services revealed if a resident was unattended in the dining room or in the Malahide lounge, adjacent to the dining room, and was in distress, the resident would have no way of summoning for assistance.
c) An observation of the dining room and adjacent Malahide lounge revealed there is no resident - staff communication and response system available to the residents. (563)

2. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres, as evidenced by:

Audits of the resident rooms were completed on February 25, 2014.
In the Lower North wing, 6/15 (40%) resident rooms had one or more windows able to be opened greater than 15 cm.
In the Lower South wing, 13/15 (87%) resident rooms had one or more windows able to be opened greater than 15 cm.
In the Upper North wing, 15/15 (100%) resident rooms had one or more windows able to be opened greater than 15 cm.
In the Upper South wing, 13/15 (87%) resident rooms had one or more windows able to be opened greater than 15 cm.

78% of all resident rooms in the home have one or more windows able to be opened greater than 15 cm.

The Director of Senior Services and the Manager of Resident Care confirmed that the windows could be opened more than 15 centimetres.

(514)

3. The licensee has failed to ensure that all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door, as evidenced by:

An audit of residents rooms was completed on February 25, 2014.
On Lower North wing, 15/15 (100%) residents rooms have doors leading to the outside of the home, that are locked with a key lock.
On Lower South wing, 14/15 (93.3%) resident rooms have doors leading to the outside of the home, that are closed with a push button lock and are able to be opened by residents.
On Upper North wing, 15/15 (100%) resident rooms have doors leading to an outside balcony, that are closed with a push button lock and are able to be opened by residents.
On Upper South wing, 14/15 (93.3%) resident rooms have doors leading to an outside balcony, that are closed with a push button lock and are able to be opened by residents.

43/60 (72%) of all resident rooms have doors leading to the outside of the home that are able to be opened by residents.
60/60 (100%) of all resident rooms have doors leading to the outside of the home that are not equipped with a door access control system that is kept on at all times, and equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

(514)

4. The licensee has failed to ensure that the home is a safe and secure environment for its residents as evidenced by:

a) During the initial tour on February 24, 2014, Inspectors # 213 and # 563 observed the stairwell, connecting the ground and second floors, to be open.

The opening was measured at 60 inches wide. At the top, there are two metal posts secured to the floor, 20 inches apart.The stairwell is near the elevator where residents are transported to and from the dining room.
The opening poses a potential fall risk to residents who may try to access the stairs.

b) Inspectors # 137 and # 514 observed a housekeeping cart to be locked but unattended on the basement level, in a location accessible to residents. Two containers of disinfectant and one container of toilet bowl cleaner were observed on top of the cart.
The Director of Seniors Services shared the home's expectation that the housekeeping cart should not be left unattended and chemicals kept inaccessible to residents

c) Inspectors # 514 and # 563 observed a maintenance cart to be locked but unattended inside Upper South Home Area, near a tub room. Power tools, spray chemicals, batteries, electrical cords, bolts and screws were observed on the top of the cart.
Later the same day, all four inspectors observed the maintenance cart to be locked but unattended on the basement level, in a location accessible to residents. Power tools, spray chemicals, batteries, electrical cords, bolts and screws were observed on the top of the cart.
The Building Maintenance Manager and Director of Seniors Services shared the home's expectation that the maintenance cart should not be left unattended and tools, etc. kept inaccessible to residents.

(137)

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

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

and the Director

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

Ontario

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

Ministère 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

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 6th day of March, 2014

Signature of Inspector / Signature de l'inspecteur : Marian C. Mac Donald

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

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