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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
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347 rue Preston bureau 420
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 12, 2019	2019_625133_0014 (A1)	008142-19	Follow up

Licensee/Titulaire de permis

Mohawk Council of Akwesasne
P.O. Box 579 CORNWALL ON K6H 5T3

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

Tsiionkwanonhsote
70 Kawehnoke Apartments Road Akwesasne ON K6H 5R7

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

Amended by JESSICA LAPENSEE (133) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance order due date has been amended upon request from the licensee. The compliance order due date was September 16, 2019. The compliance order due date has been extended to December 16, 2019. No other changes have been made.

Issued on this 12nd day of September, 2019 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

Amended by JESSICA LAPENSEE (133) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 14, 18, 19, 2019 (on-site)

The following intake was completed in the Follow Up inspection: Log #008142-19, which was related to bed system maintenance.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Food Services Supervisor, the Recreation and Leisure Manager, the Maintenance Supervisor, a Restorative Care Aide and Registered and Non-Registered Nursing staff.

During the course of the inspection, the Inspector reviewed manufacturer manuals for the various types of bed systems in use throughout the home, reviewed documentation related to bed system inspection and maintenance, observed residents' bed systems.

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

During the course of the original inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	Légende 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,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with compliance order (CO) #002 from Follow up Inspection #2019_761733_0005. The CO report date was April 16, 2019 and the CO had a compliance due date (CDD) of May 17, 2019.

The licensee was ordered to comply with O. Reg. 79/10, s. 90 (2) (a), and, to specifically comply with the following items:

1. Ensure that all identified bed system maintenance issues from January, 2019 and any subsequent issues are corrected and that this process is documented.

2. Develop a written preventative maintenance program for residents bed systems that meets manufacturer specifications at a minimum.

3. Ensure that all manufacturer specifications for all bed systems and bed system components, such as bed frames, mattresses and bed rails, are available within the home.

4. Where the home does not have manufacturer specifications, the home is to contact the manufacturer in order to obtain said specifications.

5. Ensure that written documentation related to the preventative maintenance program is kept and maintained.

The licensee failed to comply with O. Reg. 79/10, s. 90 (2) (a), as well as items #1, #2 as outlined in the CO.

The licensee failed to comply with item #1 in that all identified bed system maintenance issues from January 2019, and subsequently identified issues, were not corrected.

The licensee failed to comply with item #2 in that a written preventative maintenance program for residents bed systems that meets manufacturer specifications at a minimum was not developed.

The licensee failed to comply with O. Reg. 79/10, s. 90 (2) (a) in that a preventative maintenance program for residents bed systems that meets manufacturer specifications at a minimum was not implemented.

In relation to bed system maintenance issues, identified in January 2019 and subsequently:

On June 14, 2019, the Inspector interviewed the Maintenance Supervisor (MS,

#101) and the Restorative Care Aide (RCA, #102). It was determined that the home had three main types of beds in the home: Basic American (BA), MC Healthcare (MC) and Invacare. The MS indicated that they had re-inspected all of the residents' bed systems in the company of the RCA, beginning on April 4, 2019. The MS indicated that they had fixed what they could, such as tightening bed rails, and that whatever parts they did not have, such a mattress keepers, went on a list to be ordered. The RCA indicated that following this re-inspection process, an outside service provider had come into the home on April 24, 2019 and had inspected all of the residents' bed system with a focus on bed rail entrapment zone testing. The RCA indicated that the outside service provider identified additional equipment that was required, such as kits to ensure Invacare assist rails remained tight, and rail caps for Invacare assist rails. The RCA explained rail caps are required at the base of assist rails (x2) on the Invacare beds, to cover the metal and to ensure that a resident's skin can not be cut if contact occurs when the rails are in the up position. As well, the RCA indicated that they had previously understood that a specified type of bed system (MC) did not have the option of mattress keepers (a.k.a. mattress stops). The RCA indicated that the outside service provider had informed that this type of bed system did require mattress keepers and that they could be ordered. As per documentation provided by the home, there were approximately eight BA beds in use, 26 Invacare beds in use, and 13 MC beds in use.

As per the User Manual for Invacare beds, as provided by the home "The mattress keeper rods are an integral part of the bed rail system. By securing the mattress in place, the mattress keeper rods prevent unsafe gaps from forming between the bed ends or rails and the mattress. Install the mattress keeper rods correctly to decrease the risk of patient entrapment" (page 32/33)

As per the User manual for the MC beds as provided by the home "WARNING! POSSIBLE INJURY OR DEATH The Mattress Stops help control the Entrapment Zone gaps between the Mattress, Side Rails, the Head and the Foot Boards. Improper installation or absence of Mattress Stops could result in entrapment injury or death. Ensure the Mattress fills the entire width and length of the sleeping deck with the corners of the Mattress snuggly fitted within the Mattress Stops" (page 3)

Following the MS and RCA's bed re-inspection process, that began on April 4, 2019, it was documented that there remained seven identified beds that still required mattress keepers. As well, four identified beds were noted as requiring a

holster for the bed remote.

On June 19, 2019, the Inspector observed eight of the beds referenced above and confirmed the mattress keepers and/or holsters were still missing. Inspector observed that on an identified bed, the left side assist rail was very loose. This was reported to the Maintenance Supervisor (MS, #101), who subsequently attempted to tighten the rail. The MS indicated the rail could not be tightened with what they had to work with in the home. The MS indicated that they would purchase the required parts the following day and would attempt to tighten the rail again.

As per the spreadsheet that documented the April 24, 2019 bed system inspection process by an outside service provider, additional beds were noted as requiring mattress keepers and the need for rail caps and tightening kits for some Invacare assist rails was identified.

As per an email provided to the Inspector, all of the required equipment for all of the residents' bed systems was ordered on June 10, 2019.

On June 18, 2019, the Administrator indicated that once all of the required equipment was received, an outside service provider would be in to install all of the parts, and to provide in-service education to maintenance staff, housekeeping staff, and to some Personal Support Workers.

In summary, the licensee failed to ensure that all identified bed system maintenance issues from January, 2019, and any subsequent issues, were corrected.

Related to the development and implementation of a written preventative maintenance program for residents' bed systems that meets manufacturer specifications, at a minimum.

On June 14, 2019, the Inspector interviewed the Maintenance Supervisor (MS, #101). The MS indicated that the home was working on developing a written preventative maintenance program for the residents' beds. The MS indicated the program would be based on manufacturer specifications.

On June 18, 2019, the Inspector interviewed the Administrator (#103) and the

Director of Care (#104), concurrently. The Administrator provided the Inspector with a document titled "Bed Audit and Maintenance Program" (the document), which was developed by the RAI Coordinator (#105). Within the document, it was indicated that the home would have a program that provides for routine inspections and maintenance for resident bed systems and bed rails in the home. Within the document, it was indicated that the Maintenance Manager/Lead would develop a program to provide for routine inspections and maintenance to the bed systems in accordance to the manufacturer's manuals (the program). It was noted by the Administrator and the DOC that the program had not yet been developed. The DOC explained that where the document referenced the "Maintenance Manager/Lead", it was meant as reference to the Maintenance Supervisor (MS, #101). The DOC indicated that the MS was not yet aware of the program referenced in the document, as it had not yet been put into place. The DOC informed that it would be further discussed at the next bed committee meeting, on June 28, 2019. The document did not include any information about manufacturer specification for maintenance for the various bed systems in the home. The DOC indicated that an equipment record had been created for each bed in the home. On each record, with the exception of five beds (Drive Medical), it was indicated that "manual recommends q6m". There was nothing further about what was to be done to each bed every 6 months. The Administrator indicated they would contact the RAI coordinator, to verify if there was something missing that would outline what was to be done, and when.

On June 19, 2019, the Administrator provided the Inspector with a document titled "Annual/Semi Annual Resident Room Checklist". On page 3 of 8, there was a section titled "Room Beds". This section specified 13 inspection items, 11 of which related to bed system maintenance. The Administrator indicated that the RAI coordinator had provided the checklist to them via email the previous evening. The Administrator, and the DOC, indicated that this checklist would be reviewed at the June 28, 2019 meeting, and the team would decide if it would be put into use.

The Inspector reviewed all related user manuals, as provided by the home, for the various types of beds in use. The manufacturers' specifications for maintenance were not reflected in the checklist.

On June 20, 2019, the Inspector interviewed the RAI Coordinator (RC #105) on the telephone. The RC indicated that the checklist was a work in progress, not a final product. The RC indicated that the document titled "Bed Audit and

Maintenance Program", and the checklist, was adapted from a policy and procedure that had been purchased from another long-term care provider. The RC indicated that they had not worked with the manufacturer manuals to develop the checklist. The RC indicated that they would now work on updating the checklist, in accordance to the maintenance specified in the manuals. The RC indicated there would be further discussion at the June 28, 2019 meeting as to how the preventative maintenance program, once developed, could be implemented.

On June 24, 2019, the Inspector spoke with the Administrator on the telephone. The Administrator indicated that the RC had now developed additional checklists, to capture the maintenance requirement for the beds in the home, as per the manufacturer specifications. The Administrator indicated these checklists, and the program, would be further discussed at the June 28, 2019 meeting, including how to implement the program.

In summary, the licensee failed to develop and implement a written preventative maintenance program for residents' bed systems that meets manufacturer specifications, at a minimum.

In conclusion, the decision to reissue the compliance order is based on the following:

The severity of non-compliance was such that there was minimal risk of harm to the residents in relation to bed system maintenance.

The scope of the non-compliance identified was widespread, in that it applied to all bed systems in the home.

Related to the licensee's compliance history, the Compliance Order (CO) is reissued to the same section and subsection, O. Reg. 79/10, s. 90 (2) (a), related to bed system maintenance. CO #002 was initially served to the licensee on April 16, 2019 as a result of Follow up Inspection #2019_761733_0005. The licensee has been issued an additional nine COs within the last 36 months, two of which were reissued to the same section and subsection, as described below.

Initially resulting from Complaint Inspection #2018_619550_004, CO#002 was related to O. Reg. 79/10, s. 19(1) and was issued in April 2018. The CO was reissued in October 2018 as a result of Resident Quality Inspection (RQI)

#2018_583117_0007. The CO was complied in April 2019, as a result of Follow Up Inspection #2019_761733_0005.

Initially resulting from RQI #2018_583117_0007, CO #002 was related to O. Reg. 79/10, s. 15 (1) and was issued in October 2018. The CO was reissued in April 2019, as a result of Follow up Inspection #2019_761733_0005. The CO due date is August 16, 2019. [s. 90. (2) (a)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use all equipment, supplies and devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

On June 19, 2019, the Inspector noted that the home had five beds in use, manufactured by an identified manufacturer.

As per the manufacturer's identified operating manual, these beds are intended for use within a homecare environment.

On June 24, 2019, via email, the Administrator informed the Inspector that four of these five beds had been recently purchased and put into use. The fifth bed had been brought into the home by a resident. The Administrator indicated that the company that sold the beds to the home would be taking them back and replacing them with beds that are suitable for use in long-term care. On June 25, 2019, via email, the Administrator indicated that the fifth bed would also be replaced.

On July 5, 2019, during a telephone conversation, the Administrator indicated that the beds would be replaced the week of July 8, 2019. [s. 23.]

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 with the requirement to ensure that staff use all equipment, supplies, devices, assitive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

Issued on this 12nd day of September, 2019 (A1)

[redacted]

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

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JESSICA LAPENSEE (133) - (A1)
Inspection No. / No de l'inspection :	2019_625133_0014 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	008142-19 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 12, 2019(A1)
Licensee / Titulaire de permis :	Mohawk Council of Akwesasne P.O. Box 579, CORNWALL, ON, K6H-5T3
LTC Home / Foyer de SLD :	Tsiionkwanonhsote 70 Kawehnoke Apartments Road, Akwesasne, ON, K6H-5R7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Vincent Barry Lazore

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 Mohawk Council of Akwesasne, 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

Ministère de la Santé et des Soins de longue durée

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

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) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_761733_0005, CO #002;

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 must comply with O. Reg. 79/10, s. 90 (2) (a).

Specifically, the licensee shall:

1. Develop and implement a written preventative maintenance program for residents' bed systems that meets manufacturer specifications, at a minimum. Preventative maintenance performed on the bed systems is to be documented.

2. Correct all bed system maintenance issues that had been identified and documented prior to the Follow Up inspection.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order (CO) #002 from Follow up Inspection #2019_761733_0005. The CO report date was April 16, 2019 and the CO had a compliance due date (CDD) of May 17, 2019.

The licensee was ordered to comply with O. Reg. 79/10, s. 90 (2) (a), and, to specifically comply with the following items:

1. Ensure that all identified bed system maintenance issues from January, 2019 and any subsequent issues are corrected and that this process is documented.

2. Develop a written preventative maintenance program for residents bed systems that meets manufacturer specifications at a minimum.

3. Ensure that all manufacturer specifications for all bed systems and bed system components, such as bed frames, mattresses and bed rails, are available within the home.

4. Where the home does not have manufacturer specifications, the home is to contact the manufacturer in order to obtain said specifications.

5. Ensure that written documentation related to the preventative maintenance program is kept and maintained.

The licensee failed to comply with O. Reg. 79/10, s. 90 (2) (a), as well as items #1,

#2 as outlined in the CO.

The licensee failed to comply with item #1 in that all identified bed system maintenance issues from January 2019, and subsequently identified issues, were not corrected.

The licensee failed to comply with item #2 in that a written preventative maintenance program for residents bed systems that meets manufacturer specifications at a minimum was not developed.

The licensee failed to comply with O. Reg. 79/10, s. 90 (2) (a) in that a preventative maintenance program for residents bed systems that meets manufacturer specifications at a minimum was not implemented.

In relation to bed system maintenance issues, identified in January 2019 and subsequently:

On June 14, 2019, the Inspector interviewed the Maintenance Supervisor (MS, #101) and the Restorative Care Aide (RCA, #102). It was determined that the home had three main types of beds in the home: Basic American (BA), MC Healthcare (MC) and Invacare. The MS indicated that they had re-inspected all of the residents' bed systems in the company of the RCA, beginning on April 4, 2019. The MS indicated that they had fixed what they could, such as tightening bed rails, and that whatever parts they did not have, such a mattress keepers, went on a list to be ordered. The RCA indicated that following this re-inspection process, an outside service provider had come into the home on April 24, 2019 and had inspected all of the residents' bed system with a focus on bed rail entrapment zone testing. The RCA indicated that the outside service provider identified additional equipment that was required, such as kits to ensure Invacare assist rails remained tight, and rail caps for Invacare assist rails. The RCA explained rail caps are required at the base of assist rails (x2) on the Invacare beds, to cover the metal and to ensure that a resident's skin can not be cut if contact occurs when the rails are in the up position. As well, the RCA indicated that they had previously understood that a specified type of bed system (MC) did not have the option of mattress keepers (a.k.a. mattress stops). The RCA indicated that the outside service provider had informed that this type of bed system did require mattress keepers and that they could be ordered. As per documentation provided by

the home, there were approximately eight BA beds in use, 26 Invacare beds in use, and 13 MC beds in use.

As per the User Manual for Invacare beds, as provided by the home "The mattress keeper rods are an integral part of the bed rail system. By securing the mattress in place, the mattress keeper rods prevent unsafe gaps from forming between the bed ends or rails and the mattress. Install the mattress keeper rods correctly to decrease the risk of patient entrapment" (page 32/33)

As per the User manual for the MC beds as provided by the home "WARNING! POSSIBLE INJURY OR DEATH The Mattress Stops help control the Entrapment Zone gaps between the Mattress, Side Rails, the Head and the Foot Boards. Improper installation or absence of Mattress Stops could result in entrapment injury or death. Ensure the Mattress fills the entire width and length of the sleeping deck with the corners of the Mattress snuggly fitted within the Mattress Stops" (page 3)

Following the MS and RCA's bed re-inspection process, that began on April 4, 2019, it was documented that there remained seven identified beds that still required mattress keepers. As well, four identfied beds were noted as requiring a holster for the bed remote.

On June 19, 2019, the Inspector observed eight of the beds referenced above and confirmed the mattress keepers and/or holsters were still missing. Inspector observed that on an identified bed, the left side assist rail was very loose. This was reported to the Maintenance Supervisor (MS, #101), who subsequently attempted to tighten the rail. The MS indicated the rail could not be tightened with what they had to work with in the home. The MS indicated that they would purchase the required parts the following day and would attempt to tighten the rail again.

As per the spreadsheet that documented the April 24, 2019 bed system inspection process by an outside service provider, additional beds were noted as requiring mattress keepers and the need for rail caps and tightening kits for some Invacare assist rails was identified.

As per an email provided to the Inspector, all of the required equipment for all of the residents' bed systems was ordered on June 10, 2019.

On June 18, 2019, the Administrator indicated that once all of the required equipment was received, an outside service provider would be in to install all of the parts, and to provide inservice education to maintenance staff, housekeeping staff, and to some Personal Support Workers.

In summary, the licensee failed to ensure that all identified bed system maintenance issues from January, 2019, and any subsequent issues, were corrected.

Related to the development and implementation of a written preventative maintenance program for residents' bed systems that meets manufacturer specifications, at a minimum.

On June 14, 2019, the Inspector interviewed the Maintenance Supervisor (MS, #101). The MS indicated that the home was working on developing a written preventative maintenance program for the residents' beds. The MS indicated the program would be based on manufacturer specifications.

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nothing further about what was to be done to each bed every 6 months. The Administrator indicated they would contact the RAI coordinator, to verify if there was something missing that would outline what was to be done, and when.

On June 19, 2019, the Administrator provided the Inspector with a document titled "Annual/Semi Annual Resident Room Checklist". On page 3 of 8, there was a section titled "Room Beds". This section specified 13 inspection items, 11 of which related to bed system maintenance. The Administrator indicated that the RAI coordinator had provided the checklist to them via email the previous evening. The Administrator, and the DOC, indicated that this checklist would be reviewed at the June 28th, 2019 meeting, and the team would decide if it would be put into use.

The Inspector reviewed all related user manuals, as provided by the home, for the various types of beds in use. The manufacturers' specifications for maintenance were not reflected in the checklist.

On June 20, 2019, the Inspector interviewed the RAI Coordinator (RC #105) on the telephone. The RC indicated that the checklist was a work in progress, not a final product. The RC indicated that the document titled "Bed Audit and Maintenance Program", and the checklist, was adapted from a policy and procedure that had been purchased from another long-term care provider. The RC indicated that they had not worked with the manufacturer manuals to develop the checklist. The RC indicated that they would now work on updating the checklist, in accordance to the maintenance specified in the manuals. The RC indicated there would be further discussion at the June 28, 2019 meeting as to how the preventative maintenance program, once developed, could be implemented.

On June 24, 2019, the Inspector spoke with the Administrator on the telephone. The Administrator indicated that the RC had now developed additional checklists, to capture the maintenance requirement for the beds in the home, as per the manufacturer specifications. The Administrator indicated these checklists, and the program, would be further discussed at the June 28, 2019 meeting, including how to implement the program.

In summary, the licensee failed to develop and implement a written preventative maintenance program for residents' bed systems that meets manufacturer specifications, at a minimum.

In conclusion, the decision to reissue the compliance order is based on the following:

The severity of non-compliance was such that there was minimal risk of harm to the residents in relation to bed system maintenance.

The scope of the non-compliance identified was widespread, in that it applied to all bed systems in the home.

Related to the licensee's compliance history, the Compliance Order (CO) is reissued to the same section and subsection, O. Reg. 79/10, s. 90 (2) (a), related to bed system maintenance. CO #002 was initially served to the licensee on April 16, 2019 as a result of Follow up Inspection #2019_761733_0005. The licensee has been issued an additional nine COs within the last 36 months, two of which were reissued to the same section and subsection, as described below.

Initially resulting from Complaint Inspection #2018_619550_004, CO#002 was related to O. Reg. 79/10, s. 19(1) and was issued in April 2018. The CO was reissued in October 2018 as a result of Resident Quality Inspection (RQI) #2018_583117_0007. The CO was complied in April 2019, as a result of Follow Up Inspection #2019_761733_0005.

Initially resulting from RQI #2018_583117_0007, CO #002 was related to O. Reg. 79/10, s. 15 (1) and was issued in October 2018. The CO was reissued in April 2019, as a result of Follow up Inspection #2019_761733_0005. The CO due date is August 16, 2019.

(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 16, 2019(A1)

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

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

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, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

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

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12nd day of September, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by JESSICA LAPENSEE (133) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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