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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 13, 2015	2015_341583_0012	H-002731-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

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

THE WOODLANDS OF SUNSET
920 PELHAM STREET WELLAND ON L3C 1Y5

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

KELLY HAYES (583), GILLIAN TRACEY (130), PHYLLIS HILTZ-BONTJE (129)

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): June 16, 17, 18, 19, 22, 23, 24, 25 and 26, 2015.

This inspection was conducted simultaneously with CI inspections #H-001447-14; H-002035-15 and Compliant inspections H-000742-14; H-001454-14; H-001666-14.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Associate Director of Care (ADOC); Dietary Housekeeping Laundry Manager; Food Service Supervisor (FSS); Registered Dietitian (RD); Clinical Documentation Informatics (CDI) Coordinator; Registered Nurses (RN); Registered Practical Nurses (RPN); Personal Support Workers (PSW); Dietary Staff; residents and families. Inspectors also reviewed relevant clinical records; policies and procedures; training records; program evaluations; critical incidents submitted by the home; the homes complaints and maintenance logs and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

10 WN(s)
4 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

A) On June 16, 23 and 24, 2015, the tub chair located on the Cedars home area was observed to have a build-up of a white residue. Staff interviewed observed the chair and confirmed the chair was not clean. (#130) [s. 15. (2) (a)]

2. The licensee failed to ensure that the equipment was maintained in a safe condition and in a good state of repair.

A) A grab bar that was fastened to a metal frame at the toilet in an identified room came apart when resident #006 grabbed it for support in 2014. The resident subsequently lost their balance and fell. Post incident, the licensee identified that the grab bar was not in a good state of repair as it had disconnected from the frame at a weakened section of the joint where it was welded together. The licensee was aware that the grab bar was loose on February 25, 2014, after completing an audit of the condition of the grab bars throughout the home. The licensee replaced 11 of the identified loose grab bars since that date, but not all grab bars of similar design. The licensee failed to ensure that immediate measures or steps were taken to ensure that all grab bars were safe for use after identifying that the grab bars were loose. (#130) [s. 15. (2) (c)]

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) The plan of care for resident #006 indicated the resident was at risk for falls and staff were to ensure that the bed was at the lowest position when the resident was in the bed and transfer height when the resident was out of the bed. On June 23, 2015, at 1400 hours, the resident was observed in their bed; however, staff confirmed the bed was at transfer height and not in its lowest position. Care was not provided in accordance with the plan of care. (#130)

B) During a dining observation in the dining room on June 16 and 24, 2015, resident #502 was observed being feed by their table mate's visitor. A review of the plan of care identified resident #502 required total feeding assistance and specifically identified one staff was to complete all tasks of eating. Resident #502 was assessed to be at high nutrition risk, at risk for swallowing and choking and had specific individualized feeding strategies for staff to follow. In an interview with the Clinical Documentation Informatics (CDI) Coordinator on June 24, 2015, it was confirmed that the homes expectation was

that resident #502 was to be feed by a staff member and the care was not provided as specified in the plan. (#583) [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care was revised at least every six months and at any other time when the residents' care needs changed or care set out in the plan was no longer necessary.

A) A review of the dietary care plan was completed on June 23, 2015, and identified resident #003 was at moderate nutrition risk and was followed quarterly or as required by the Food Service Supervisor (FSS). A review of the plan of care identified there had been changes in the resident's nutrition risk factors including a weight change to underweight, initiation of a nutrition supplement and a diet texture modification. In an interview with the Registered Dietitian (RD) on June 23, 2015, it was shared that resident #003 was currently high nutrition risk and quarterly nutrition assessments were to be completed by the RD. It was confirmed that the nutrition care plan was not revised to reflect that resident #003 was at high nutrition risk and the intervention for the FSS to follow the resident quarterly was not removed when it was no longer necessary. (#583)

B) A review of the dietary care plan was completed on June 23, 2015, and identified resident #007 was at moderate nutrition risk and was followed quarterly or as required by the FSS. A review of the "Resident Nutritional Risk Screen (Niagara Region)" tool completed on April 21, 2015, identified resident #007 was at high nutrition risk. In an interview with the RD on June 23, 2015, it was confirmed that the dietary care plan was not revised to reflect that resident #007 was at high nutrition risk and the intervention for the FSS to follow the resident quarterly was not removed when it was no longer necessary. (#583)

C) Resident #003 was not reassessed and the plan of care was not reviewed or revised when staff documented that the resident's bowel and urinary continence had deteriorated. The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment completed on December 27, 2014, indicated the resident was continent of both bladder and bowel. Staff and clinical documentation confirmed that the following RAI-MDS completed on March 13, 2015, indicated that the resident was now usually continent of urine, frequently incontinent of bowel and that the resident's urinary continence had deteriorated. Staff and clinical documentation confirmed the resident was not reassessed either through the completion of the Resident Assessment Protocol (RAP) or a continence assessment and the plan of care was not revised to address the deterioration in the resident's urinary and bowel function. (#129) [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the resident is reassessed and the plan of care is revised at least every six months and at any other time when the residents care needs changed or care set out in the plan is no longer necessary, 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 ensure that the plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act.

During a lunch observation on June 23, 2015, in the dining room resident #500 who required total feeding assistance and resident #501 who required extensive feeding assistance and monitoring for choking and aspiration were served a meal when staff members were not present at their table to provide assistance. A review of the "PCS05-007 Provision of Care, Treatment and Services Nutritional Care" policy last revised May 20, 2013, identified the delivery of a meal to resident's requiring assistance in eating would occur no more than 5 minutes in advance of assistance being provided. In an interview with front line nursing staff it was verified that resident #500 and #501 who required total assistance with eating and drinking had a portion of their meal severed for a time period greater than 20 minutes before any staff were able to provide assistance. In an interview with the Dietary, Housekeeping, Laundry Manager on June 23, 2015, it was confirmed that the homes nutrition care policy was not in compliance with and was not implemented in accordance with applicable requirements under 73(2)(b) of the Regulations. (#583) [s. 8. (1) (a)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system put in place was complied with.

The Arjo "Alenti" Operating and Daily Maintenance Instructions for the bath lift chair indicated: "Use the safety belt at all times".

On June 16, 2015, an unidentified resident was observed in the bathtub on Cedars home area, seated in the Alenti bath lift chair. The safety belt on the chair was observed hanging from the arm rest of the chair. The PSW providing care to the resident confirmed the safety belt was not fastened.

During an interview, the Administrator confirmed that it was the home's expectation that staff use the safety belt at all times, when the bath lift was in use.

The Arjo "Alenti" Operating and Daily Maintenance Instructions were not complied with. (Inspector #130) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with applicable requirements under the Act and that any plan, policy, protocol, procedure, strategy or system put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with fluids that were safe.

During a dining observation on June 16, 2015, in the dining room it was observed that the thickness of multiple beverages served to the same residents appeared varied in consistency. Front line nursing staff were observed adding thickener with a small plastic spoon that was not a measuring spoon to resident #508 and #509's fluids. In an interview with the staff member it was verified a standardized recipe was not followed and that both resident were on a pudding consistency.

During a dining observation on June 24, 2015, in the dining room the Dietary Aid (DA) was observed adding thickener to soups and beverages with a small soup spoon that was not a measuring spoon. In an interview with the DA they confirmed they were not following a recipe and the staff could not find a standardized recipe in the servery for thickening.

The DA shared the four residents who required pudding thick fluids were prepared as followed:

i) 180 milliliter (ml) cream soups were mixed with 2 small soup spoons of Thick and Easy; 125 ml beverages were mixed with 1.5 small soup spoons of Thick and Easy; 250 ml beverages were mixed with 2 heaping small soup spoons of Thick and Easy

During the dining observation some resident tables were observed to have individual jars of thickener with labeled instructions. In multiple interviews with staff it was shared that fluids were thickened by the DA, fluids were thickened at the resident tables by the PSW and RPN staff and it was shared PSW and RPN staff added additional thickener to already thickened beverages when they appeared too thin.

The recipe on the jars for pudding thick fluids were directed to be prepared as followed:

ii) mix 125 ml of fluid with 2 tablespoons (Tbsp) of Thick and Easy; mix 250 ml of fluid with 4 Tbsp of Thick and Easy

The recipe from Thick and Easy manufacturer for pudding thick fluids was provide to inspector #583 by the Dietary Housekeeping Landry Manger.

The recipe for pudding thick fluids was directed to be prepared as followed:

iii) Using a whisk or fork, mix the following amount of Thick and Easy into 100 mls of liquid. Pudding consistency 2 tablespoons.

In an interview with the Dietary Housekeeping Laundry Manager on June 24, 2015, it was confirmed that that pudding thick fluids were not prepared in the dining room following a standardized recipe or by following the Thick and Easy manufactures instructions. Staff did not measure using a standardized measuring spoon. The licensee failed to ensure residents on pudding thick consistency with swallowing risk were provided fluids that were safe as potentially less thickener was used than required when preparing pudding thick consistency menu items. (#583) [s. 11. (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 residents are provided with fluids that are safe, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that provided residents with any personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

During an observation in the dining room on June 24, 2015, resident #505 and #506 were left unattended at their table multiple times for periods greater than five minutes after their meal had been served. A review of the plan of care identified resident #505 was at high nutrition risk, required total feeding assistance and choked easily and resident #506 was at high nutrition risk and required extensive assistance with eating. A review of the staff meal service assignment identified that the PSW assisting resident #505 and #506 was assigned to take meal choices using show plates, serve all residents in the dining room and clear the dishes course by course. In an interview with the CDI Coordinator on June 25, 2015, it was verified that the PSW was unable to provide resident #505 and #506 with the level of assistance they required and due to the homes direction documented on the meal service assignment for the identified PSW to provide non direct personal care. It was confirmed the homes dining service did not provide resident #505 and #506 with the personal assistance required to eat and drink as safely as possible. (#583) [s. 73. (1) 9.]

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 home has a dining and snack service that provides residents with any personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that actions taken with respect to resident's under a program, including assessments, reassessments, interventions and the residents responses to interventions were documented.

The licensee failed to ensure that actions taken with respect to resident #200 under the falls prevention and management program were documented.

Staff did not document multidisciplinary discussions held in response to resident #200's falls. Resident #200 fell on six occasions in 2014. At the time of this inspection staff indicated that it is their practice that when a resident falls staff involved in different aspects of the care, including the Physiotherapist, gather at unit meetings to discuss the aspects of the fall and possible actions to take to manage this care focus. Staff confirmed that issues discussed and possible considerations for care planning were not documented when these meetings were held with respect to the falls resident #200 was experiencing. (#129)
(PLEASE NOTE: This non-compliance was identified during a Critical Incident System inspection – Log # H-001447-14, conducted concurrently with this inspection) [s. 30. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a Personal Assistive Services Device (PASD) used for resident #201 met the requirements to be included in the resident's plan of care in accordance with LTCH Act, 2007, c. 8, s. 33(4) 1, in relation to the following:

Resident #201 was noted to be sitting in a wheelchair with an easy release alarm seat belt applied that, when asked, the resident was not able to remove. Staff and clinical documentation confirmed that alternatives to the use of this PASD were not considered and as a result this PASD should not have been included in the resident's plan of care. (#129) [s. 33. (3)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that, in accordance with O. Reg. 79/10, s. 211 (1) 1 and 3, all staff who provided direct care to the resident received annual retaining in the areas of falls prevention and management as well as continence care and bowel management, in relation to the following:

1. The Associate Director of Care (ADOC) confirmed that unregulated nursing staff and staff from other departments who provided direct care to residents did not receive training in the area of falls prevention and management in 2014.
(PLEASE NOTE: This non-compliance was identified during a Critical Incident System inspection – Log # H-001447-14, conducted concurrently with this inspection)

2. At the time of this inspection staff in the home was unable to provide documentation to verify that all staff who provided direct care to residents received training in the area of continence care and bowel management in 2014. (#129) [s. 76. (7) 6.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a Personal Assistive Service Device (PASD) used for resident #201 was applied according to directions for use.

On June 18, 2015, resident #201 was noted to be sitting in a wheelchair with a seat belt applied and at this time the seat belt was noted to be loosely applied with a four to six inch gap between the resident's body and the seat belt. A Personal Support Worker (PSW) who was in attendance at the time confirmed that the seat belt was too loose. Documents provided by the home identified that it would be the expectation that the seat belt would be secured across the residents hips firmly so you can fit only two fingers between the seat belt and the resident's body. (#129) [s. 111. (2) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

a) On June 26, 2015, it was observed that controlled substances were stored in a locked cupboard within the locked medication room on the Maples home area. The DRC confirmed that controlled substances were not stored in a double-locked stationary cupboard in the locked area. (#130) [s. 129. (1) (b)]

Issued on this 13th day of August, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY HAYES (583), GILLIAN TRACEY (130), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2015_341583_0012
Log No. / Registre no:	H-002731-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 13, 2015
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF NIAGARA 2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7
LTC Home / Foyer de SLD :	THE WOODLANDS OF SUNSET 920 PELHAM STREET, WELLAND, ON, L3C-1Y5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BRENT KERWIN

To THE REGIONAL MUNICIPALITY OF NIAGARA, 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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the grab bars in the home are in safe condition and in a good state of repair. The plan is to include, but is not limited to:

1. An audit on the condition of grab bars throughout the home.
2. Identify what immediate interventions will be put in place to reduce or eliminate risk to residents whose grab bars were identified to be unsafe or in a poor state of repair.
3. Identify the long term plan on how the home will ensure all grab bars will be in a good state of repair by the identified compliance date.

The plan shall be submitted by September 30, 2015, to Long Term Care Homes Inspector Bernadette Susnik at Bernadette.Susnik@ontario.ca.

Grounds / Motifs :

1. The licensee failed to ensure that the equipment was maintained in a safe condition and in a good state of repair.

A grab bar that was fastened to a metal frame at the toilet in an identified room came apart when resident #006 grabbed it for support in 2014. The resident subsequently lost their balance and fell. Post incident, the licensee identified that the grab bar was not in a good state of repair as it had disconnected from the frame at a weakened section of the joint where it was welded together. The licensee was aware that the grab bar was loose on February 25, 2014, after completing an audit of the condition of the grab bars throughout the home. The licensee replaced 11 of the identified loose grab bars since that date, but not all grab bars of similar design. The licensee failed to ensure that immediate measures or steps were taken to ensure that all grab bars were safe for use after identifying that the grab bars were loose. (#130) [s. 15. (2) (c)] (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

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
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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 13th day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Hayes

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