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 le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Jul 04, 2014;	2014_217137_0016 (A1)	L-000558-14	Resident Quality Inspection

Licensee/Titulaire de permis

S & R NURSING HOMES LTD.
265 NORTH FRONT STREET, SUITE 200, SARNIA, ON, N7T-7X1

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

AFTON PARK PLACE LONG TERM CARE COMMUNITY
1200 AFTON DRIVE, SARNIA, ON, N7S-6L6

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

MARIAN MACDONALD (137) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Three compliance due dates have been extended.

Issued on this 4 day of July 2014 (A1)

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

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MARIAN MACDONALD (137) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 2-6 and June 9-12, 2014

During the course of the inspection, the inspector(s) spoke with Administrator, Manager - Resident Care, 2 Assistant Managers' - Resident Care, Manager - Food Services, Manager - Life Enrichment, Office Coordinator, Corporate Registered Dietitian, Division Manager, one Registered Nurse, 9 Registered Practical Nurses, 16 Personal Support Workers, 2 Environmental Services Workers, 3 Life Enrichment Workers, 1 Maintenance Worker, 6 Food Services Workers, 1 Laundry Worker, 2 Physiotherapy Assistants, 40+ residents and 6 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, kitchen, medication storage areas, observed resident care provision, resident-staff interactions, dining service, recreational activities, medication administration, 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

Infection Prevention and Control

Medication

Minimizing of Restraining

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment as evidenced by:

a)Observations, during a tour of the home on June 12, 2014 with the Administrator and Inspectors # 137 and # 523, revealed a bed entrapment risk for an identified resident.
During an additional tour with Inspector # 137, the Division Manager and Manager - Resident Care also observed the identified risk.

b)Inspector # 137 inquired if a bed audit had been completed. The Administrator shared an audit was completed before she commenced employment at the home.
On June 13, 2014, the Administrator provided a copy of a "Records of Facility Entrapment Inspection Records & Information, Training, Beds, Rail, Mattresses" – "Summary of Testing and Action Plan" dated 2011, to Inspector # 135.

c)A review of the 2011"Testing and Action Plan" revealed the following:
Zone 1 – all beds passed.
Zone 2 – 97/128 (75.78%) beds failed
Zone 3 – 1 bed failed
Zone 4 – 106/128 (82.81%) beds failed

d)Documented comments indicated:
We have determined that we can fix most of these issues by ordering the mattress kit, which has 4 corner mattress supports that will hold the mattress in position, eliminating the Zone 2 problem.
It also contains corners for the rails which will eliminate the Zone 4 problem.
We are also re-evaluating the type of mattress we purchase.

e)April 5, 2011 Update
We have purchased the required parts to fix the bed and railing to meet entrapment testing. We will be installing these parts as soon as possible. Maintenance Department will work on this.
Also we have purchased new type of mattress that fits the entrapment requirements.

f) The testing document does not identify the room #, bed #, make, model & serial # of

the beds, the make of the mattresses and the type of rails used to determine which Zone areas failed for each of the beds.

There is no documented evidence the Maintenance Department have implemented the identified interventions and this was confirmed by the Administrator.
The Administrator also confirmed no bed entrapment testing has been completed since 2011 and residents' assessments have not been completed to determine if their bed system (rail, mattress, frame) are appropriate for their needs. [s. 15. (1)]

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 LTCHA, 2007, 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 failed to 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 as evidenced by:

Observations, throughout the RQI revealed:

a) During two separate incidents, the electronic medication administration records (e-MAR) terminal was left open and visible on the screen, in identified common areas, while the medication cart was left unattended. Personal Health Information (PHI) was readily accessible. Two registered staff members confirmed the e-MAR terminals were not locked and PHI was readily accessible. Both shared each resident's PHI should be kept confidential and not accessible. (Inspector # 515)

b) During the initial tour on an identified Resident Home area by Inspectors # 515 and # 523, the Physiotherapy room door was open, the folder cabinet was unlocked, open and keys were in the door, the resident physiotherapy services folder and resident care plans were on the table, with no staff in visual proximity of the area. Personal Health Information (PHI) was readily accessible. Two identified staff members confirmed the PHI was readily accessible and both shared the expectation is to have room locked when no staff member is in visual proximity of the area, to ensure resident PHI is not accessible.

c) During four separate incidents, on three identified Resident Home Areas, the Resident Care Centre doors were not locked and there was no staff member in close visual proximity. Personal Health Information, such as shift reports, laboratory requisitions, head injury routine, vital signs records, restraint assessment record, computer terminal logged on to Point Click Care (PCC) and residents' clinical records were readily accessible. (Inspectors # 137 and # 523)
Interviews with a Personal Support Worker and a Registered Staff Member confirmed the doors were not locked and Residents' PHI was readily accessible.
The Administrator confirmed the home's expectation is the Resident Care Centre doors are to be locked when no staff member is in visual proximity of the area, to ensure resident PHI is kept confidential and not readily accessible.

d) During two separate medication administrations, on two identified Resident Home Areas, registered staff members discarded the empty medication strip packages in the general garbage receptacle, at the side of each medication cart. Each strip package contained PHI and was not altered in any way, prior to disposal, to protect the resident's identity. Two registered staff members confirmed the strip packages are placed in the general garbage and then disposed of in the dumpster by an Environmental Service Worker, without deliberate alteration to protect resident PHI.
The Administrator and Manager - Resident Care confirmed PHI should not be disposed of in the regular garbage and the expectation is resident PHI be protected, kept confidential and not readily accessible. (Inspectors # 137 and # 523) [s. 3. (1) 8.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

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

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

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 there is an organized program of maintenance services for the home as evidenced by:

a)A review of the preventive maintenance schedules and an interview with the Administrator revealed the maintenance program has not been fully implemented and monitored.

b)The home has been without a Manager - Environmental Services since the end of November, 2013.
The Administrator is responsible for Environmental Services in the interim.

c)One of the duties identified on the daily preventive maintenance schedule for the month of May, 2014 indicates:
"Check all lighting - replace bulbs where required".
There is documented evidence that this was checked off for each day in May except week-ends and on two Fridays. Observations throughout the RQI revealed several burnt out light bulbs in ceilings/wall sconces in dining rooms, hallways, chapel and Community Area.
As of June 10, 2014, lights remain burnt out in chapel, Community Area, small dining room sconces and two light fixtures in the hallway, just outside the Administration office.
The Administrator confirmed the lights had not been checked and bulbs replaced.

d)The monthly preventive maintenance schedule indicates call bells will be checked quarterly, on each home area, for ringing and cord replacement. The schedule reveals 1E, including cafe area and front entrance, was checked in May 2014. Observations revealed the call bell at the main entrance door was pinned up with push pins and not accessible, as well as seven identified call bell cords were wrapped around the urgent frame plate, unable to be activated when pulled.
The Administrator confirmed call bells had not been consistently checked to ensure access.

e)Wall repairs check and paint schedule are identified on the 52 Week Preventive Maintenance Schedule. There is no documented evidence that wall repairs and painting were completed and this was confirmed by the Administrator.

f)Carpet cleaning is not identified on any of the Preventive Maintenance schedules. Carpets were observed to be heavily soiled/stained throughout the home. There is no documented evidence to support the carpets had been cleaned. The Administrator confirmed carpet cleaning was not identified on the Preventive Maintenance schedules and there is no documented evidence to support the carpets had been cleaned.

g)A review of the "Action Plan For Environmental Services for 2013-2014" revealed:
- extra hours for cleaning carpets - high priority - due date by end of March, 2014

- painting of tub/shower rooms, 2 dining rooms, non-resident washrooms, Resident Care Centre walls and touch up painting around the home - high priority - due date February 28-March 31, 2014.
- plan to clean all carpets in the home - to be cleaned immediately by unit - due date April 30, 2014.
The Administrator confirmed the Action Plan was not carried through and there was inconsistent monitoring of the maintenance program. [s. 15. (1) (c)]

2. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary as evidenced by:

Observations, throughout the RQI, revealed:
a) Cob webs and dust hanging from the ceiling in front of the Chapel hallway.
b) Thick dust in chapel air vents and hallway vent, outside of chapel.
c) Fixtures and air vent visibly dusty and floor visibly soiled in 1W dining room.
d) Cob webs in the corner of the Community Area, to the left of Life Enrichment Room.
e) Carpets heavily soiled and stained throughout all Home Areas and Family Apartment.

An interview with an Environmental Services Worker and Administrator confirmed the observations and the expectation is the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

3. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair as evidenced by:

Observations, during the initial tour and throughout the RQI, revealed:

1st Floor:
a) Rust on the door frame and door leading to the outside (close to corridor E3 entrance – 1E).
b) Hole in the wall under the Infection Control Education board.
c) Wallpaper peeling off the walls in the main lounge-entrance. Scrapes and chipped paint on walls.
e) Resident Lounge (1W) – arm chair arm broken, scrapes on legs of chair.
f) Resident kitchen (1W) – gouge on wall under window, bugs in light fixtures.
g) Dining room (1W) – I baseboard tile off in the corner and chipped paint on door frame.
h) Café – peeling paint below hanger.

i) 1E Tub room - three broken tiles and a hole in the wall.
j) 1E Shower room - water/moisture damage to the cabinet.
k) In an identified resident room - Wooden bathroom door and closet door scratched; Baseboard damaged to left of bathroom door entrance; wall damaged opposite the foot of the bed and to the right of the bed; hole in wall behind bedroom door approximately 10 cm X 3.5 cm.
l) In an identified resident room - Bedroom, bathroom and closet door frames with chipped paint. Wall damaged to the left of closet. Wooden bedroom door damaged. Wall under window damaged. There is a hole in the wall, under electrical outlet, on left side of window, approximately 8cm X 2.5 cm.
m) In an identified resident room - Closet and bedroom door frames with chipped paint.
Wall damaged to the left of the bathroom door entrance.
n) In an identified resident room - Bedroom and bathroom door frames with chipped paint; full length of lower wall damaged, to right of room entrance; wall damaged in bathroom; wall damaged on left side of resident's bed; wall damaged above resident's bed.
o) In an identified resident room - Bedroom and bathroom door frames with chipped paint. Wall damaged above name plate in hallway.
p) In an identified resident room - Chipped paint on bathroom door frame; bathroom door gouged on lower inside area; wall damaged to the left of bedroom entrance; wall damaged to the right of bathroom door entrance; hole in wall, approximately 6cm X 3cm, to left of bed; wall damaged to the right of closet.
q) In an identified resident room - Chipped paint on bathroom door frame; bathroom door gouged on lower inside area; wall damaged to the left of bedroom entrance.

2nd Floor
r) Stained ceiling tiles two identified resident rooms.
s) 2W - Private dining room – door sticks.
t) Sink cabinet damaged, exposing sharp edges in shared washroom in an identified resident room.
u) Large brown spots on ceiling above bed in an identified resident room; patched, unpainted walls; paint chipped door frames.
v) Holes in the wall and drywall gouged beside wall shelf in an identified resident room.
w) 2W - Shower floor has a hole and a slit in it.
x) 2E - several broken tiles in shower and tub rooms;
y) Several lights burnt out in ceilings/wall sconces in dining rooms, hallways, chapel and Community Area.

The observations were confirmed by a Personal Support Worker (PSW), a Registered Staff member and by the Administrator.
The Administrator shared the expectation is that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 004

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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:

Observations, throughout the RQI, revealed:

a)Call bells were wrapped around the urgent frame plate and not able to be activated when pulled in Resident Kitchen (1W), Chapel and Resident Laundry Room (1W), Family Kitchen and Dining Room areas on second floor close to 2E and Private Dining Room (2W).
Call bell at main entrance door was pinned up with push pins and unable to be accessed.
Call bell in an identified resident room was missing the push button and could not be activated.

b)Windows opened beyond 15 cm in Family Kitchen (1E - 40cm), Kitchenette between Café and Dining Room (1E - 40 cm), area off Private Dining Room (2W - 40 cm) and Sunroom on 2nd floor (16.5 cm).

c)Door to patio is not locked during the day, with access to BBQ's, propane tank not secured and gardening supplies accessible to residents (shovels and trowels).

d)1W tub room door was open with a container of Endbac disinfectant on the counter, accessible to residents.

e)On June 2, 2014, 2E eye washing station door was open (unable to lock) containing an unlocked housekeeping cart with laundry detergent, Virox 5RTU and Diversey cleanser accessible to residents.
On June 12, 2014, 2E eye washing station door was open (unable to lock) containing traffic lane cleanser and insecticide.

f)Temperature in 2E shower room was 19.3 C.

Observations were confirmed by two Environmental Service Workers, two Registered Staff members, a Maintenance Worker, the Administrator and the Division Manager. The Administrator shared the expectation is the home is a safe and secure environment for its residents. [s. 5.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide care to the resident as evidenced by:

A review of the care plan for an identified resident indicated an intervention for falls was to ensure the resident has a seat belt on when in the wheelchair.
The resident was observed without a seat belt on, while seated in the wheelchair.
A review of quarterly Minimum Data Set (MDS) assessments for an identified time

frame, revealed documentation for devices and restraints specific to 'chair prevents rising' was coded as not used.

A registered staff member shared the resident does not use a seat belt while sitting in the wheelchair and confirmed the care plan does not provide clear directions to staff who provide care to the resident.

The Manager - Resident Care and Administrator confirmed the expectation is the care plan is to provide clear direction to staff and others who provide care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that an assessment for the use of alternatives to restraints was completed before applying the restraints, as evidenced by:

A review of the clinical record, for an identified resident, revealed there was no documented evidence of an assessment for Alternatives to Restraints and Risk of Restraint being completed prior to applying the restraint.

An interview with the Manager - Resident Care confirmed there was no assessment completed and the home's expectation is to have an assessment for Alternative to Restraints and Risk of Restraint completed prior to applying a restraint. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other as evidenced by:

An identified resident was observed seated in a tilt wheelchair, in a reclined position, and was unable to independently be positioned upright.
A review of clinical records, for the identified resident, revealed there was no documented evidence of the Alternatives to Restraints or PASD Assessment form being completed.

An interview with the Manager - Resident Care confirmed there was no assessment completed and the home's expectation is the Alternatives to Restraints or PASD Assessment be completed. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, as evidenced by:

A review of the Activity Participation Report for an identified resident, revealed activity programs were not provided to the resident, as set out in the plan of care.

The Life Enrichment Worker and the Administrator confirmed the home's expectation is to have personalized care plans for residents, that care be provided to residents as specified in the plan and residents, with cognitive impairment and unable to leave the room, should receive one to one visits at least weekly. [s. 6. (7)]

5. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan as evidenced by:

A documented intervention in the Care Plan for an identified resident indicates oral care is to provided after meals.

A Personal Support Worker confirmed oral care was not provided after meals.
A Registered staff member confirmed that the care set out in the plan of care is not provided to the resident as specified in the plan. [s. 6. (7)]

6. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan as evidenced by:

The plan of care for an identified resident indicates the resident was to receive specific life enrichment interventions.

A review of the Activity Participation Report for an identified time frame, revealed the resident was not consistently provided life enrichment interventions, as specified in the plan of care.

The Administrator confirmed there is no documented evidence that the resident was provided life enrichment activities as per the care plan and the expectation that care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide care to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, as evidenced by:

A review of the home's Pain and Symptom Management Policy and Procedure # RCM 10-04-01, Dated June 30, 2013, indicated:
#6. At the conclusion of the 7 day pain monitoring, a summary progress note with the data from the MAR and/or progress notes will be completed. The effectiveness of the new, changed or discontinued pain medication, pain levels and interventions should be included in this summary note.

A review of the clinical record, for an identified resident, indicated a change in medication administration time due to increased pain intensity.
There was no documented evidence of a summary progress note having been completed following a 7 day pain monitoring assessment, for the identified resident.

A Registered Staff member confirmed a progress note was not completed and the expectation is the home's policy on Pain and Symptom Management be complied with. [s. 8. (1) (a),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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

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 the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, in accordance with the requirements provided in the regulations as evidenced by:

An identified resident was observed to have a seat belt in place while sitting in a wheelchair and was not able to undo the seat belt independently.
A review of the resident's clinical record revealed that there was no documented evidence of an order to apply restraint by the physician or the registered nurse in the extended class and there was no consent by the resident or SDM. A wheelchair seat belt restraint was identified in this resident's care plan.

The Manager - Resident Care confirmed that this seat belt is a restraint and the home's expectation is there should be a physician's order and consent for the seat belt restraint. [s. 31. (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 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 the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, in accordance with the requirements provided in the regulations, to be implemented voluntarily.

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

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Findings/Faits saillants :

1. The licensee has failed to 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 as evidenced by:

A review of the clinical health record for an identified resident revealed there is no documented evidence that the resident uses a tilt wheelchair in the PASD focus section of the care plan, the use of the PASD has not been approved by a physician and there is no written consent for the use of the PASD by a substitute decision-maker with authority to give that consent.

The Manager - Resident Care confirmed there was no documented evidence for a tilt wheelchair in the PASD focus section of the care plan, no physician's order and no written consent on the resident's health care record and the home's expectation is these documents should be in the resident's clinical record. [s. 33.]

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 Personal Assistance Services Device (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, to be implemented voluntarily.

WN #9: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated as evidenced by:

A review of the clinical health record for an identified resident, with altered skin integrity, revealed there was no documented evidence the resident had any pressure ulcers and the resident was not reassessed for skin and wound concerns, at least weekly, by a member of the registered nursing staff.

A Registered Staff member confirmed weekly skin assessments were not completed and when an assessment is completed for any reason, a head to toe assessment is also completed and all skin issues are documented on the assessment.

The Manager - Resident Care confirmed the expectation that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, types of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence as evidenced by:

A review of the clinical record for an identified resident revealed there is no documented evidence that a continence assessment was completed since admission to the home.

The Assistant Manager - Resident Care - Quality confirmed the resident did not receive a continence assessment and the expectation is the resident who is incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

2. A review of the clinical record for an identified resident revealed the resident is incontinent and the resident's continence condition is deteriorating.

During the identified time frame, there is no documented evidence that incontinence assessments, using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, were completed on the resident.

An interview with the Assistant Manager - Resident Care confirmed that the resident had no continence assessments completed and the expectation that a resident who is incontinent receive an assessment using a clinically appropriate assessment tool. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, types of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The Licensee failed to ensure that the Winter/Spring 2013/2014 menu cycle was approved by a registered dietitian who is a member of the staff of the home as evidenced by:

Interview with the Manager - Food Services revealed the home's Winter/Spring menu cycle was implemented December 9, 2013. As of June 12, 2014, the home's Registered Dietitian has not approved the therapeutic menu cycle for the Winter/Spring menu cycle. The Manager - Food Services shared that the new Summer/ Fall menu cycle will be implemented mid July 2014.

In an interview the Manager of Food Services confirmed the expectation is that the home's menu cycle is approved by the home's Registered Dietitian. [s. 71. (1) (e)]

2. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack when the following occurred:

During lunch service, June 12, 2014 in Mayfair dining room the following planned menu items were not available as per the planned menu:

Chicken Caesar Salad, Tea Biscuit and Oatmeal Raisin Cookie

During an interview with the Manager - Food Services, he confirmed the menu had to be changed as he had not ordered the menu items as per the planned menu.

In an interview the Manager - Food Services confirmed his expectation that the planned menu items are offered and available at each meal and snack. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's menu cycle is approved by a registered dietitian who is a member of the staff of the home and planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure that there were standardized recipes for all menus when the following occurred:

A record review with the Manager - Food Services revealed that 13/44 (29.5%) of the standardized recipes reviewed for the lunch menu June 11, 2014 and the lunch and dinner menus for June 12, 2014 were not available to assist staff in food production. Some of the standardized recipes missing included:

Apple Pie, minced Apple Pie and puree Apple Pie, Macaroni Salad, Coleslaw, and minced Seasoned Spinach

In an interview with the Manager - Food Services it was confirmed the home's expectation is that there are standardized recipes for all meals to guide staff in the production of the menu items for residents. [s. 72. (2) (c)]

2. The Licensee failed to ensure that all food is served using methods which preserve taste, nutritive value, appearance and food quality when the following occurred:

During lunch June 12, 2014, in Mayfair dining room the appearance/consistency of the minced beef and minced chicken was observed as being a very fine particle size, 1-2 mm and not the 6 mm (1/4 inch) particle size as per the home's policy, Diet Preparing Puree and Minced textures #FS 10-28 , April 2014.

In an interview the Manager - Food Services confirmed his expectations that the minced diet texture be 6 mm (1/4 inch) and that all food is served using methods which preserve taste, nutritive value, appearance and food quality. [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there are standardized recipes for all menus and all food is served using methods which preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #13: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes a review of the meal and snack times by the Residents' Council as evidenced by:

On June 11, 2014, no documented evidence of discussion about meal and snack times was found in a review of Residents' Council meeting minutes from January 2013 to May 2014.
A representative of the Residents' Council confirmed there is no discussion at council meetings regarding meal and snack times.

The Administrator confirmed that meal and snack times are not discussed at Residents' Council meetings. [s. 73. (1) 2.]

2. The licensee failed to ensure that food and fluids are served at temperatures that is both safe and palatable to the residents when the following occurred:

Interviews with residents revealed food is often cold or lukewarm.

During dinner service in Somerset dining room June 12, 2104, 6/8 menu items (75%) when probed were lower than the home's minimum meal service temperature of 140F as follows:

Spinach Puree-127.2 F
Puree Lemon Herb Fish -102F
Seasoned Spinach- 137.6F
Lemon Dill Salmon-104.7F
Herb Roasted Potatoes-119.1F
BBQ Pork Riblette-114.6 F

During an interview the Manager - Food Services, it was confirmed the home's expectation is that hot foods are maintained at a minimum temperature of 140F as per the home policy to ensure that foods and fluids are served at a temperature that is both safe and palatable to the residents. [s. 73. (1) 6.]

3. The licensee has failed to ensure that, (b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident as evidenced by:

Observations during a breakfast meal revealed an identified resident, who requires assistance, was served a meal and did not receive assistance for 29 minutes.

The Manager - Food Services confirmed no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident and the expectation is assistance be provided, as well as, food be served at the proper temperature. [s. 73. (2) (b)]

4. Observations during a lunch meal revealed an identified resident, who requires assistance, was served a meal while the resident was seated in a tilted chair. The resident waited 5 minutes before being positioned upright and receiving set up

assistance, to enable the resident to be independent with feeding.

A PSW confirmed the resident had not been provided assistance with set up, at that time.

Observations during a breakfast meal revealed an identified resident, who requires assistance, was served a meal and did not receive assistance for 14 minutes.

An interview with the Corporate Dietitian and Manager - Food Services confirmed the expectation is no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. [s. 73. (2) (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 home has a dining and snack service that includes a review of the meal and snack times by the Residents' Council, food and fluids are served at temperatures that is both safe and palatable to the residents and no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are implemented for cleaning of the home, including,
ii. common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces, as evidenced by:

Observations, throughout the RQI revealed:

Carpets were observed to be heavily soiled and stained throughout all Home Areas and the Family Apartment.
There was no documented evidence that carpet cleaning was scheduled on the Preventive Maintenance Schedule, as well as no documented evidence when the carpets were last cleaned.
A review of a 2013-2014 Environmental Services Action Plan revealed extra hours for cleaning carpets were to be scheduled and carpet cleaning to be completed by the end of March 2014.

The Administrator confirmed the carpets were soiled and the expectation is the carpets be cleaned and free of stains. [s. 87. (2) (a) (ii)]

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 procedures are implemented for cleaning of the home, including,
ii. common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #15: 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 has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked as evidenced by:

On three separate occasions, a medication cart was observed to be unlocked and unattended in the hallway, outside an identified dining room. The registered staff members were administering medication in the dining room and were not in visual proximity of the medication cart.

The Registered staff members confirmed the medication cart was unlocked and the home's expectation is the medication cart and eMAR terminal be kept secure and locked. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

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

Observations, throughout the RQI, revealed:

a) In an identified washroom - unlabeled personal items including body lotion, toothpaste, barrier cream and deodorant on counter and dresser.

b) In an identified washroom - urine measuring hat sitting on the floor, unlabeled body lotion and denture brush on the counter.

c) In an identified washroom - unlabeled bottles of deodorant and shave cream, visibly soiled k-basin containing 2 unlabeled and soiled combs.

d)2 West Tub Room - soiled combs and nail clippers in storage boxes. No documented evidence of nail clippers and storage boxes cleaned in May 2014 per the posted cleaning schedule. Unlabeled personal items, such as a bottle of body wash/shampoo and shaving cream sitting on the side of the tub and body lotion beside the sink. A plastic three drawer organizer containing unlabeled and visibly

soiled hairbrushes, 1 bottle of shaving cream, 1 bottle with NO label to identify the contents, 1 tube gel mist toothpaste with hair stuck to the screw cap, 2 deodorant spray cans, 1 deodorant spray with no cap and 1 nail clipper.

e)2 West Shower Room - Unlabeled Calmoseptine ointment and body lotion, bathing and hand wash on sink counter, raised toilet seat laying on the floor against the wall, unlabeled urinal, visibly soiled Care Caddy containing unlabeled deodorant spray, shaving cream, body cream, 1 pair rusted nail clippers, 1 tube barrier cream, 1 visibly soiled hairbrush, 1 glove, 1 pair of visibly soiled goggles and 1 jig saw puzzle piece.

f)Call bell cords observed laying on the floor in 6 identified resident washrooms, 2 West Tub Room and open area inside entrance to 2 East Somerset.

g)During medication administration, a registered staff member was observed not practicing hand hygiene between residents.

h)A Personal Care Worker (PCW) cleaned up spilled juice on the hallway floor, using two bath towels and feet. The PCW confirmed an Environmental Service Worker should have been called.

i)An unlabeled urinal on the shower wall and an unlabeled blue washbasin on floor under the sink on 1W.

j)Two breakfast trays were observed being delivered to residents on tray service and the meals were not covered.

Observations were confirmed by 3 Registered staff members, 3 Personal Support Workers, 1 Life Enrichment Worker, 2 Environmental Service Workers and the Manager - Food Services.
The Administrator shared the home's expectation is that staff are expected to participate in the implementation of the infection prevention and control program. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written record of each annual evaluation of the staffing plan, as evidenced by:

A review of the home's staffing plan revealed that there is no documented evidence of a written record of an annual evaluation of the staffing plan and the Administrator confirmed there was no written record of an annual evaluation. [s. 31. (4)]

WN #18: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents’ Council in developing and carrying out the survey, and in acting on its results as evidenced by:

A review of Residents' Council meeting minutes from Jan 2013 to May 2014, revealed the home had not sought the advice of the Residents' Council in developing and carrying out the satisfaction survey.

A representative of the Residents' Council and the Administrator confirmed the home had not sought the advice of the Residents' Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

2. The licensee has failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results as evidenced by:

A representative of the Family Council and the Administrator confirmed the home had not sought the advice of the Family Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

Issued on this 4 day of July 2014 (A1)

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

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

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

London Service Area Office
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MARIAN MACDONALD (137) - (A1)

Inspection No. / No de l'inspection : 2014_217137_0016 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : L-000558-14 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jul 04, 2014;(A1)

Licensee / Titulaire de permis : S & R NURSING HOMES LTD.
265 NORTH FRONT STREET, SUITE 200, SARNIA, ON, N7T-7X1

LTC Home / Foyer de SLD : AFTON PARK PLACE LONG TERM CARE COMMUNITY
1200 AFTON DRIVE, SARNIA, ON, N7S-6L6

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

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

To S & R NURSING HOMES LTD., 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 :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

(A1)
The licensee must take immediate action to achieve compliance to ensure where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. O. Reg. 79 10, s.15(1)(a)(b)

1. Immediate interventions must be implemented to mitigate risks to residents that use one or more bed rails, for beds that failed any zone of entrapment. This includes all beds, whether the mattress is foam based or not.
2. Assessments of residents must be completed to determine if their bed system (rail, mattress, frame) are appropriate for their needs.

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79 10, s.15(1)(a)(b). The plan shall:

1. Identify the room #, bed #, make, model & serial # of the beds, the make of the mattresses and type of rails used, as well as which zones failed for each of the beds.
2. Include dates when resident assessments will be completed and care plans updated.
3. Include how education will be provided, to all direct care staff, with respect to bed safety, including who will be responsible.
4. Include a copy of the home s bed safety policies and procedures.
5. Identify what long-term actions will be implemented to ensure beds continue to pass all zones of entrapment and how ongoing resident assessments will be completed, including who will be responsible and time frames.

Please submit the plan, in writing, to Marian C. Mac Donald, Long-Term Care Nursing Homes 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 July 25, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment as evidenced by:

- Observations, during a tour of the home on June 12, 2014 with the Administrator and Inspectors # 137 and # 523, revealed a bed entrapment risk for an identified resident.
During an additional tour with Inspector # 137, the Division Manager and Manager of Resident Care also observed the identified risk.

- Inspector # 137 inquired if a bed audit had been completed. The Administrator shared an audit was completed before she commenced employment at the home. On June 13, 2014, the Administrator provided a copy of a "Records of Facility Entrapment Inspection Records & Information, Training, Beds, Rail, Mattresses" – "Summary of Testing and Action Plan" dated 2011, to Inspector # 135.

- A review of the 2011"Testing and Action Plan" revealed the following:
Zone 1 – all beds passed.
Zone 2 – 97/128 (75.78%) beds failed
Zone 3 – 1 bed failed
Zone 4 – 106/128 (82.81%) beds failed

- Documented comments indicated:
We have determined that we can fix most of these issues by ordering the mattress kit, which has 4 corner mattress supports that will hold the mattress in position, eliminating the Zone 2 problem.
It also contains corners for the rails which will eliminate the Zone 4 problem.
We are also re-evaluating the type of mattress we purchase.

- April 5, 2011 Update
We have purchased the required parts to fix the bed and railing to meet entrapment testing. We will be installing these parts as soon as possible. Maintenance Department will work on this.

Also we have purchased new type of mattress that fits the entrapment requirements.

- The testing document does not identify the room #, bed #, make, model & serial # of the beds, the make of the mattresses and the type of rails used, as well as which zone areas failed for each of the beds.

- There is no documented evidence the Maintenance Department have implemented the identified interventions and this was confirmed by the Administrator.
The Administrator also confirmed no bed entrapment testing has been completed since 2011 and residents' assessments have not been completed to determine if their bed system (rail, mattress, frame) are appropriate for their needs. (137)

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

Sep 30, 2014(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed

and cared for in a manner consistent with his or her needs.

5. Every resident has the right to live in a safe and clean environment.

6. Every resident has the right to exercise the rights of a citizen.

7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.

8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

9. Every resident has the right to have his or her participation in decision-making respected.

10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.

11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information

concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or

the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

(A1)
LTCHA, 2007, S.O., 2007, c.8, 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.

The licensee must take immediate action to achieve compliance by:
a) ensuring each resident s Personal Health Information (PHI) is kept secured, confidential and not readily accessible when no staff member is present.
b) ensuring all staff, who have access to each resident s Personal Health Information (PHI), are provided education related to every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Grounds / Motifs :

1. The licensee failed to 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 as evidenced by:

Observations, throughout the RQI revealed:

a) During two separate incidents, the electronic medication administration records (e-MAR) terminal was left open and visible on the screen, in identified common areas, while the medication cart was left unattended. Personal Health Information (PHI) was readily accessible.
Two registered staff members confirmed the e-MAR terminals were not locked and PHI was readily accessible. Both shared each resident's PHI should be kept confidential and not accessible. (Inspector # 515)

b) During the initial tour on an identified Resident Home Area by Inspectors # 515

and # 523, the Physiotherapy room door was open, the folder cabinet was unlocked, open and keys were in the door, the resident physiotherapy services folder and resident care plans were on the table, with no staff in visual proximity of the area. Personal Health Information (PHI) was readily accessible.
Two identified staff members confirmed the PHI was readily accessible and both shared the expectation is to have room locked when no staff member is in visual proximity of the area, to ensure resident PHI is not accessible.

c) During four separate incidents, one on three identified Resident Home Areas, the Resident Care Centre doors were not locked and there was no staff member in close visual proximity. Personal Health Information, such as shift reports, laboratory requisitions, head injury routine, vital signs records, restraint assessment record, computer terminal logged on to Point Click Care (PCC) and residents' clinical records were readily accessible. (Inspectors # 137 and # 523)
Interviews with a Personal Support Worker and a Registered Staff Member confirmed the doors were not locked and residents' PHI was readily accessible.
The Administrator confirmed the home's expectation is the Resident Care Centre doors are to be locked when no staff member is in visual proximity of the area, to ensure resident PHI is kept confidential and not readily accessible.

d) During two separate medication administrations, on two identified Resident Home Areas, registered staff members discarded the empty medication strip packages in the general garbage receptacle, at the side of each medication cart. Each strip package contained PHI and was not altered in any way, prior to disposal, to protect the resident's identity.
Two registered staff members confirmed the strip packages are placed in the general garbage and then disposed of in the dumpster by an Environmental Service Worker, without deliberate alteration to protect resident PHI.
The Administrator and Manager - Resident Care confirmed PHI should not be disposed of in the regular garbage and the expectation is resident PHI be protected, kept confidential and not readily accessible.
(Inspectors # 137 and # 523)

(137)

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

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

Jul 18, 2014(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home;
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

Order / Ordre :

LTCHA, 2007, S.O. 2007, c.8, s. 15. (1) Every licensee of a long-term care home shall ensure that,
(c) there is an organized program of maintenance services for the home.

The licensee must take immediate action to achieve compliance by:
a) ensuring there is an organized program of maintenance services for the home.
b) ensuring there is ongoing monitoring of the maintenance services for the home.

Grounds / Motifs :

1. The licensee has failed to ensure that there is an organized program of maintenance services for the home as evidenced by:

(a) A review of the preventive maintenance schedules and an interview with the Administrator revealed the maintenance program has not been fully implemented and monitored.

(b) The home has been without a Manager - Environmental Services since the end of November, 2013
The Administrator is responsible for Environmental Services in the interim.

(c) One of the duties identified on the daily preventive maintenance schedule for the month of May, 2014 indicates:
"Check all lighting - replace bulbs where required".
There is documented evidence that this was checked off for each day in May except week-ends and on two Fridays. Observations throughout the RQI revealed several burnt out light bulbs in ceilings/wall sconces in dining rooms, hallways, chapel and Community Area.
As of June 10, 2014, lights remain burnt out in chapel, Community Area, small dining room sconces and two light fixtures in the hallway, just outside the Administration office.
The Administrator confirmed the lights had not been checked and bulbs replaced.

(d)The monthly preventive maintenance schedule indicates call bells will be checked quarterly, on each home area, for ringing and cord replacement. The schedule reveals 1E, including cafe area and front entrance, was checked in May 2014. Observations revealed the call bell at the main entrance door was pinned up with push pins and not accessible, as well as seven identified call bell cords were wrapped around the urgent frame plate, unable to be activated when pulled. The Administrator confirmed call bells had not been consistently checked to ensure access.

(e) Wall repairs check and paint schedule are identified on the 52 Week Preventive Maintenance Schedule. There is no documented evidence that wall repairs and painting were completed and this was confirmed by the Administrator.

(f) Carpet cleaning is not identified on any of the Preventive Maintenance schedules. Carpets were observed to be heavily soiled/stained throughout the home. There is

no documented evidence to support the carpets had been cleaned. The Administrator confirmed carpet cleaning was not identified on the Preventive Maintenance schedules and there is no documented evidence to support the carpets had been cleaned.

(g) A review of the "Action Plan For Environmental Services for 2013-2014" revealed:
- extra hours for cleaning carpets - high priority - due date by end of March, 2014
- painting of tub/shower rooms, 2 dining rooms, non-resident washrooms, Resident Care Centre walls and touch up painting around the home - high priority - due date February 28-March 31, 2014.
- plan to clean all carpets in the home - to be cleaned immediately by unit - due date April 30, 2014

The Administrator confirmed the Action Plan was not carried through and there was inconsistent monitoring of the maintenance program.

(137)

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

Aug 29, 2014

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A1)
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.

The licensee must take immediate action to achieve compliance by:
a) ensuring cob webs and dust are cleaned and removed from the ceiling in front of the Chapel and in the corner of the Community Area.
b) ensuring dust is cleaned and removed from the air vents in the Chapel and hallway, outside of the chapel.
c) ensuring dust is cleaned and removed from the light fixtures, air vent and soil removed from floor in 1W dining room.
d) ensuring soil stains are cleaned and removed from carpets throughout all identified areas.

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee must take immediate action to achieve compliance by:
a) ensuring damaged and paint chipped doors, door frames, walls and base boards, throughout the home, are repaired and painted.
b) ensuring damaged wallpaper, in identified locations, is repaired or replaced.
c) ensuring the damaged armrest and legs, of an identified lounge chair, is repaired.
d) ensuring the tiles are repaired or replaced in the 1E, 2E and 2W shower tub rooms.

e) ensuring the damaged cabinets are repaired in 1E shower room and Room 275.
f) ensuring the damaged flooring is repaired in 2W shower room.
g) ensuring stained ceiling tiles are replaced in Room # 259, # 276 and in an identified hallway.
h) ensuring all burnt out light bulbs are replaced in ceiling light fixtures wall sconces throughout the home.

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, S.O. 2007, c.8, s. 15. (2)(a) and LTCHA, 2007, S.O. 2007, c.8, s. 15. (2)(c) to ensure the home, furnishings and equipment are kept clean and sanitary and the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The plan must include what immediate and long-term actions will be undertaken to correct the identified deficiencies, as well as 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 July 25, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary as evidenced by:

Observations, throughout the RQI, revealed:
- Cob webs and dust hanging from the ceiling in front of the Chapel hallway.
- Thick dust in chapel air vents and hallway vent, outside of chapel.
- Fixtures and air vent visibly dusty and floor visibly soiled in 1W dining room.
- Cob webs in the corner of the Community Area, to the left of Life Enrichment Room.
- Carpets heavily soiled and stained throughout all Home Areas and Family Apartment.

An interview with an Environmental Services Worker and Administrator confirmed the observations and the expectation is the home, furnishings and equipment are kept clean and sanitary.

(137)

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair as evidenced by:

Observations, during the initial tour and throughout the RQI, revealed:

1st Floor:
(a) Rust on the door frame and door leading to the outside (close to corridor E3 entrance – 1E).
(b) Hole in the wall under the Infection Control Education board.
(c) Wallpaper peeling off the walls in the main lounge-entrance. Scrapes and chipped paint on walls.
(c) Resident Lounge (1W) – arm chair arm broken, scrapes on legs of chair.
(e) Resident kitchen (1W) – gouge on wall under window, bugs in light fixtures .
(f) Dining room (1W) – I baseboard tile off in the corner and chipped paint on door frame.
(g) Café – peeling paint below hanger.
(h) 1E Tubroom - three broken tiles and a hole in the wall.
(i) 1E Shower room - water/moisture damage to the cabinet.

(j) In an identified resident room - Wooden bathroom door and closet door scratched; Baseboard damaged to left of bathroom door entrance; wall damaged opposite the foot of the bed and to the right of the bed; hole in wall behind bedroom door approximately 10 cm X 3.5 cm.
(k) In an identified resident room - Bedroom, bathroom and closet door frames with chipped paint. Wall damaged to the left of the closet. Wooden bedroom door damaged.
Wall under window damaged. There is a hole in the wall, under electrical outlet, on left side of window, approximately 8cm X 2.5 cm.
(l) In an identified resident room - Closet and bedroom door frames with chipped paint.
Wall damaged to the left of the bathroom door entrance.
(m) In an identified resident room - Bedroom and bathroom door frames with chipped paint; full length of lower wall damaged, to right of room entrance; wall damaged in bathroom; wall damaged on left side. of resident's bed; wall damaged above resident's bed.
(n) In an identified resident room - Bedroom and bathroom door frames with chipped paint. Wall damaged above name plate in hallway.
(o) In an identified resident room - Chipped paint on bathroom door frame; bathroom door gouged on lower inside area; wall damaged to the left of bedroom entrance; wall damaged to the right of bathroom door entrance; hole in wall, approximately 6cm X 3cm, to left of bed; wall damaged to the right of a closet .
(p) In an identified resident room - Chipped paint on bathroom door frame; bathroom door gouged on lower inside area; wall damaged to the left of bedroom entrance.

2nd Floor
(q) Stained ceiling tiles two identified resident rooms.
(r) 2W - Private dining room – door sticks.
(s) Sink cabinet damaged, exposing sharp edges in shared washroom in an identified resident room.
(t) Large brown spots on ceiling above bed in an identified resident room; patched, unpainted walls; paint chipped door frames.
(u) Holes in the wall and drywall gouged beside wall shelf in an identified resident room.
(v) 2W - Shower floor has a hole and a slit in it.
(w) 2E - several broken tiles in shower and tub rooms.
(x) Several lights burnt out in ceilings/wall sconces in dining rooms, hallways, chapel and Community Area.

The observations were confirmed by a Personal Support Worker (PSW), a Registered Staff member and by the Administrator.
The Administrator shared the expectation is that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. (137)

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

Sep 30, 2014(A1)

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

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.

The licensee must take immediate action to achieve compliance by:
a) ensuring all resident-staff communication response systems are accessible, in good repair and able to be activated.
b) ensuring every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.
c) ensuring propane tanks are secured and gardening tools are not left unattended and accessible to residents.
d) ensuring all areas, where chemicals are stored, are locked and not accessible to residents.
e) ensuring all areas, accessible to residents, are maintained at the minimum temperature of 22 degrees Celsius.

Grounds / Motifs :

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

Observations, throughout the RQI, revealed:

a) Call bells were wrapped around the urgent frame plate and not able to be activated when pulled in Resident Kitchen (1W), Chapel and Resident Laundry Room (1W), Family Kitchen and Dining Room areas on second floor close to 2E and Private Dining Room (2W).
Call bell at main entrance door was pinned up with push pins and unable to be accessed.
Call bell in an identified resident room was missing the push button and could not be activated.
Call bell in washroom of an identified resident room was wrapped around the grab bar and could not be activated.

b) Windows opened beyond 15 cm in Family Kitchen (1E - 40cm), Kitchenette between Café and Dining Room (1E - 40 cm), area off Private Dining Room (2W - 40 cm) and Sun Room on 2nd floor (16.5 cm).

c) Door to patio is not locked during the day, with access to BBQ's, propane tank not

secured and gardening supplies accessible to residents (shovels and trowels).

d) 1W tub room door was open with a container of Endbac disinfectant on the counter, accessible to residents.

e) On June 2, 2014, 2E eye washing station door was open (unable to lock) containing an unlocked housekeeping cart with laundry detergent, Virox 5RTU and Diversey cleanser accessible to residents.
On June 12, 2014, 2E eye washing station door was open (unable to lock) containing traffic lane cleanser and insecticide.

f) Temperature in 2E shower room was 19.3 C.

Observations were confirmed by two Environmental Service Workers, two Registered Staff members, a Maintenance Worker, the Administrator and the Division Manager. The Administrator shared the expectation is the home is a safe and secure environment for its residents.
(137)

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

Aug 29, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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 4 day of July 2014 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARIAN MACDONALD - (A1)

Service Area Office /
Bureau régional de services : London