Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 12, 2016	2015_346133_0046	O-000547-14	Follow up

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

BURNBRAE GARDENS LONG TERM CARE RESIDENCE
320 BURNBRAE ROAD EAST P.O. BOX 1090 CAMPBELLFORD ON K0L 1L0

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 17th, 18th, 2015

This inspection was in follow up to Compliance Order #002, related to lighting levels in the home, served on the licensee on June 16th, 2014, as a result of Resident Quality Inspection #2014_365194_0004.

During the course of the inspection, the inspector(s) spoke with the Administrator and the maintenance worker

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 18 in that the licensee failed to ensure that the lighting requirements set out in the lighting table were maintained.

The long term care home was built prior to 2009 and therefore the section of the lighting table that was applied is titled "all other homes".

An inspection (#2014_365194_0004) was previously conducted, in June 2014, and non-compliance (Compliance Order #002) was issued on June 16th, 2014, regarding insufficient lighting levels throughout the home. The order required the licensee to correct the non-compliance by June 30th, 2015. Specifically, the licensee was ordered to

"ensure that required lighting levels of lighting are provided in all areas of the long term care home including: a minimum of 215.28 lux of continuous lighting in corridors; a minimum level of 215.28 lux in all resident bedrooms, program/lounge space, tub and shower rooms".

Inspector #133 conducted a follow up inspection to Compliance Order #002 on November 17th and 18th, 2015. A hand held digital light meter was used (Amprobe LM-120, accurate to +/- 5%) to measure the lux in all corridors, program/lounge space, the tub and shower room, the main dining room, and some resident bedrooms. The light meter was held a standard 30 inches above and parallel to the floor. If all lights were not turned on at the time the inspector entered an area, they were turned on and allowed to warm up for at least 10 minutes, including all wall mounted over bed lights in the bedrooms. Table and floor lamps that were provided by the residents were not included in the lighting measurement. When measuring light levels in resident bedrooms, or common areas such as the spa room, the doors were closed at the time of observation in order to eliminate the influence of the hallway lighting on the meter readings. When light levels were measured during the day time in resident bedrooms, window coverings were drawn, in effort to reduce the influence of natural light. As well, where light levels were measured during the daytime in semi-private resident bedrooms, the privacy curtain for bed #2 was drawn, in further effort to reduce the influence of natural light in the area of the entrance vestibule and around bed #1. Where the influence of natural light could not be decreased by these efforts, the light levels were not measured. When light levels were measured in the evening, in resident bedrooms and in common areas, window coverings were not drawn, due to the absence of the influence of natural light.

The Administrator informed the inspector that the licensee's corrective actions included the addition of ceiling light fixtures and upgrading of lighting in existing ceiling fixtures. The inspector found that these corrective actions resulted in compliant lighting levels in many areas, however some areas remained non-compliant. Lighting levels throughout the corridors, the activity room and the small dining room were found to be above the minimum requirement of 215.28 lux. Lighting levels throughout the spa room, with the exception of within the shower stall, as described below, were found to be above the minimum requirement of 215.28 lux. Lighting levels throughout the large dining room, with the exception of two corner areas, as described below, were found to be above the minimum requirement of 215.28 lux. Lighting levels in some areas of nine resident bedrooms, as described below, were below the minimum requirement of 215.28 lux.

Related to lighting in the bedrooms, within the entrance vestibule, there was ceiling

mounted semi flush circular fixture (entrance light) with an opaque lens, which held two compact fluorescent bulbs. The entrance light served to illuminate the path in and out of the bedroom, the adjoining bathroom, and the area around furnishings within the entrance vestibule, such as closets and dressers. There was a wall mounted light above every resident's bed. As well, within the bed area of all bedrooms, there was a varying number of sets of ceiling mounted fluorescent tube lights (troffer lights). In private bedrooms, there was one set of troffer lights, perpendicular to the bed, towards the foot of the bed. In semi-private bedrooms, there were two sets of troffer lights, beginning perpendicular to the edge of the foot of bed #1 and extending along the foot of bed #2, towards the window and closet area for bed #2. In ward rooms, there were three sets of troffer lights, in a line down the center of the room, between the foot of the beds, beginning perpendicular to the foot of the first beds, extending along the foot of the second beds. Corner areas in bedrooms were only measured if there were closets or comfortable easy chairs in the area.

Specific details of the continuing non-compliance related to lighting levels, as noted by inspector #133, are as follows:

Bedroom #33 (ward room): Lighting levels were measured throughout this bedroom during the evening, between 5pm and 7pm, on November 17th, 2015. In front of resident #002's closet, the highest level of lighting measured was 163 lux. In front of resident #003's closet, the highest level of lighting measured was 135 lux. The ceiling mounted troffer lights did not serve to adequately illuminate the corner areas of this bedroom, where two of the four resident closets were located.

Bedroom #31 (ward room): Lighting levels were measured throughout this bedroom during the evening, between 5pm and 7pm, on November 17th, 2015. In front of resident #004's closet, the highest level of lighting measured was 120 lux. In front of resident #005's closet, the highest level of lighting measured was 160 lux. The ceiling mounted troffer lights did not serve to adequately illuminate the corner areas of this bedroom, where two of the four resident closets were located.

It is noted that the influence of natural light could not be prevented, in the back corners of ward room, on November 18th, 2015, as it was a bright day and the windows curtains were sheer. Inspector #133 could therefore not obtain additional light level measurements for these areas of concern in ward rooms.

Large dining room: Lighting levels were measured throughout the dining room during the

evening, between 5pm and 7pm, on November 17th, 2015. At the time of the inspection, this room was served by seven sets of ceiling mounted troffer lights and a ceiling fan in the center area with three compact fluorescent bulbs in it. At table #3, at resident # 003's seat, the highest level of lighting measured was 130 lux. At table #8, at the seat closest to the window, the highest level of lighting measured was 140 lux. The ceiling mounted troffer lights in closest proximity to these tables did not serve to adequately illuminate these corner areas.

Bedroom #38 (private): Lighting levels were measured in this bedroom during the evening on November 17th, 2015, between 5pm and 7pm, and again on November 18th, 2015, during the daytime, between 10:30am and 2pm. Directly under the entrance light, the highest level of lighting measured was 142 lux. At the wall that separates the entrance vestibule from the bed area, in the centre, the highest level of lighting measured was 113 lux. At the edge of the resident's dresser (edge closest to the entrance vestibule), before the bed, the highest level of lighting measured was 120 lux. Between the bed and the closet, the highest level of lighting measured was 176 lux. In front of the brown comfortable easy chair, towards the back right corner of the room, the highest level of lighting measured was 135 lux. The entrance light did not serve to adequately illuminate the entrance vestibule area, nor did the troffer light above the bed serve to adequately illuminate all areas of the bed space.

Bedroom #40 (private): Lighting levels were measured in this bedroom during the evening on November 17th, 2015, between 5pm and 7pm, and again on November 18th, 2015, during the daytime, between 10:30am and 2pm. Directly under the entrance light, the highest level of lighting measured was 165 lux. Directly in front of the dresser, within the entrance vestibule, the highest level of lighting measured was 150 lux. At the wall the separates the entrance vestibule from the bed area, in the centre, the highest level of lighting measured was 122 lux. Between the bed and the closet, the highest level of lighting measured was 175 lux. Towards the back right corner, in front of the comfortable easy chair which was next to the television, the highest level of lighting measured was 165 lux. Towards the back left corner, in front of the comfortable easy chair which was next to the small table with pictures on it, the highest level of lighting measured was 130 lux. Between that chair and the side of the bed, the highest level of lighting measured was 153 lux. The entrance light did not serve to adequately illuminate the entrance vestibule area, nor did the troffer lights above the bed serve to adequately illuminate all areas of the bed space.

Bedroom #23 (semi-private): Lighting levels were measured throughout this bedroom

during the evening, between 5pm and 7pm, on November 17th, 2015. The influence of natural light prevented light level measurements in this bedroom during the daytime, on November 18th, 2015. Directly under the entrance light, in the immediate area of resident #001's closet, the highest level of lighting measured was 169 lux. Between bed #1 and the side wall, in front of the chair next to the bed side table, the highest level of lighting measured was 175 lux. The entrance light did not serve to adequately illuminate the entrance vestibule area, nor did the troffer lights serve to adequately illuminate all areas around bed #1.

Spa room: Lighting levels were measured throughout this room during the evening on November 17th, 2015, between 5pm and 7pm, and again on November 18th, 2015, during the daytime, between 10:30am and 2pm. There were no windows in this room. In the center of the shower stall, with the spa room door closed and with the shower curtain closed, the highest level of lighting measured was 60 lux. With the shower curtain open, facing outwards, the highest level of lighting measured was 104 lux. The shower stall was equipped with a circular ceiling mounted fixture and the area directly outside of the shower stall was served by a set of troffer lights.

Bedroom #41 (private): Lighting levels were measured throughout this bedroom on November 18th, 2015, between 11:20am and 2pm. In addition to previously referenced bedroom lighting, this bedroom was also served by a wall mounted fixture, to the right of the bed (when facing the bed). Directly under the entrance light, in front of the resident's closet, the highest level of lighting measured was 141 lux. In front of the brown reclining chair in the corner, the highest level of lighting measured was 135 lux. The entrance light did not serve to adequately illuminate the entrance vestibule area, nor did the troffer lights above the bed serve to adequately illuminate the corner area.

Bedroom #24 (semi-private): Lighting levels were measured throughout this bedroom on November 18th, 2015, between 11:20am and 2pm. Directly under the entrance light, the highest level of lighting measured was 173 lux. In front of the closet for bed #1, the highest level of lighting measured was 183 lux. The entrance light did not serve to adequately illuminate the entrance vestibule area, nor did the troffer lights serve to adequately illuminate all areas around bed #1.

Bedroom #22 (semi-private): Lighting levels were measured throughout this bedroom on November 18th, 2015, between 11:20am and 2pm. Directly under the entrance light, the highest level of lighting measured was 186 lux. In front of resident # 006's closet, the highest level of lighting measured was 179 lux. The entrance light did not serve to

adequately illuminate the entrance vestibule area, nor did the troffer lights serve to adequately illuminate all areas around bed #1.

Bedroom #29 (semi-private): Lighting levels were measured throughout this bedroom on November 18th, 2015, between 11:20am and 2pm. Directly under the entrance light, the highest level of lighting measured was 177 lux. In front of resident #007's closet, the highest level of lighting measured was 178 lux. The entrance light did not serve to adequately illuminate the entrance vestibule area, nor did the troffer lights serve to adequately illuminate all areas around bed #1.

It was noted by inspector #133 that some of the non-compliance observed in some semi-private and private resident rooms, as opposed to the ward rooms, was due to the distance between entrance light and the troffer lights within the bed areas. In the ward rooms, the troffer lights were approximately four feet from the entrance light. Consequently, in these rooms, the troffer lights added illumination to the entrance vestibule area and to the space between the first beds and the walls, on both sides of the room. In the semi-private rooms, the troffer lights were approximately nine feet from the entrance vestibule light. In these rooms, the troffer lights did not add illumination to the entrance vestibule and added less illumination to the space between bed #1 and side wall. In private rooms, the troffer lights were also approximately 9 feet from the entrance vestibule light. In these rooms, the troffer lights did not add illumination to the entrance vestibule and added less illumination to the space between the bed and the side wall, where the closet was typically located. In addition, in the private rooms, the troffer lights did not adequately illuminate the corners areas of the rooms, where the comfortable easy chair(s) were typically located.

The minimum required amount of 215.28 lux was not achieved in all areas of the home, as specifically identified above. This continuing pattern of non-compliance requires that the Compliance Order be reissued. Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents. Insufficient lighting may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents, including to conduct assessments and to provide treatments. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility, nutritional intake, and overall quality of life. [s. 18.]

Additional Required Actions:

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

Issued on this 12th day of January, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2015_346133_0046
Log No. / Registre no:	O-000547-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 12, 2016
Licensee / Titulaire de permis :	Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	BURNBRAE GARDENS LONG TERM CARE RESIDENCE 320 BURNBRAE ROAD EAST, P.O. BOX 1090, CAMPBELLFORD, ON, K0L-1L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	April Faux

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_365194_0004, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

In order to comply with O. Reg. 79/10, s. 18, the licensee will ensure that a minimum of 215.28 lux is provided in all areas of all resident bedrooms, the large dining room and the spa room as identified below:

a) the entrance vestibule area in semi private and private bedrooms;

b) the area between the bed and the side wall in semi private and private bedrooms;

c) the back corner areas of private rooms, where comfortable easy chairs are located;

d) the back corner areas of ward rooms, where closets are located;

e) in the large dining room at the identified seats at table #3 and table #8; and

f) in the spa room in the shower stall.

Grounds / Motifs :

1. The licensee failed to comply with O. Reg. 79/10, s. 18 in that the licensee failed to ensure that the lighting requirements set out in the lighting table were maintained.

The long term care home was built prior to 2009 and therefore the section of the lighting table that was applied is titled “all other homes”.

An inspection (#2014_365194_0004) was previously conducted, in June 2014, and non-compliance (Compliance Order #002) was issued on June 16th, 2014, regarding insufficient lighting levels throughout the home. The order required the licensee to correct the non-compliance by June 30th, 2015. Specifically, the licensee was ordered to “ensure that required lighting levels of lighting are provided in all areas of the long term care home including: a minimum of 215.28 lux of continuous lighting in corridors; a minimum level of 215.28 lux in all resident bedrooms, program/lounge space, tub and shower rooms".

Inspector #133 conducted a follow up inspection to Compliance Order #002 on November 17th and 18th, 2015. A hand held digital light meter was used (Amprobe LM-120, accurate to +/- 5%) to measure the lux in all corridors, program/lounge space, the tub and shower room, the main dining room, and

some resident bedrooms. The light meter was held a standard 30 inches above and parallel to the floor. If all lights were not turned on at the time the inspector entered an area, they were turned on and allowed to warm up for at least 10 minutes, including all wall mounted over bed lights in the bedrooms. Table and floor lamps that were provided by the residents were not included in the lighting measurement. When measuring light levels in resident bedrooms, or common areas such as the spa room, the doors were closed at the time of observation in order to eliminate the influence of the hallway lighting on the meter readings. When light levels were measured during the day time in resident bedrooms, window coverings were drawn, in effort to reduce the influence of natural light. As well, where light levels were measured during the daytime in semi-private resident bedrooms, the privacy curtain for bed #2 was drawn, in further effort to reduce the influence of natural light in the area of the entrance vestibule and around bed #1. Where the influence of natural light could not be decreased by these efforts, the light levels were not measured. When light levels were measured in the evening, in resident bedrooms and in common areas, window coverings were not drawn, due to the absence of the influence of natural light.

The Administrator informed the inspector that the licensee's corrective actions included the addition of ceiling light fixtures and upgrading of lighting in existing ceiling fixtures. The inspector found that these corrective actions resulted in compliant lighting levels in many areas, however some areas remained non-compliant. Lighting levels throughout the corridors, the activity room and the small dining room were found to be above the minimum requirement of 215.28 lux. Lighting levels throughout the spa room, with the exception of within the shower stall, as described below, were found to be above the minimum requirement of 215.28 lux. Lighting levels throughout the large dining room, with the exception of two corner areas, as described below, were found to be above the minimum requirement of 215.28 lux. Lighting levels in some areas of nine resident bedrooms, as described below, were below the minimum requirement of 215.28 lux.

Related to lighting in the bedrooms, within the entrance vestibule, there was ceiling mounted semi flush circular fixture (entrance light) with an opaque lens, which held two compact fluorescent bulbs. The entrance light served to illuminate the path in and out of the bedroom, the adjoining bathroom, and the area around furnishings within the entrance vestibule, such as closets and dressers. There was a wall mounted light above every resident's bed. As well, within the bed area of all bedrooms, there was a varying number of sets of

ceiling mounted fluorescent tube lights (troffer lights). In private bedrooms, there was one set of troffer lights, perpendicular to the bed, towards the foot of the bed. In semi-private bedrooms, there were two sets of troffer lights, beginning perpendicular to the edge of the foot of bed #1 and extending along the foot of bed #2, towards the window and closet area for bed #2. In ward rooms, there were three sets of troffer lights, in a line down the center of the room, between the foot of the beds, beginning perpendicular to the foot of the first beds, extending along the foot of the second beds. Corner areas in bedrooms were only measured if there were closets or comfortable easy chairs in the area.

Specific details of the continuing non-compliance related to lighting levels, as noted by inspector #133, are as follows:

Bedroom #33 (ward room): Lighting levels were measured throughout this bedroom during the evening, between 5pm and 7pm, on November 17th, 2015. In front of resident #002's closet, the highest level of lighting measured was 163 lux. In front of resident #003's closet, the highest level of lighting measured was 135 lux. The ceiling mounted troffer lights did not serve to adequately illuminate the corner areas of this bedroom, where two of the four resident closets were located.

Bedroom #31 (ward room): Lighting levels were measured throughout this bedroom during the evening, between 5pm and 7pm, on November 17th, 2015. In front of resident #004's closet, the highest level of lighting measured was 120 lux. In front of resident #005's closet, the highest level of lighting measured was 160 lux. The ceiling mounted troffer lights did not serve to adequately illuminate the corner areas of this bedroom, where two of the four resident closets were located.

It is noted that the influence of natural light could not be prevented, in the back corners of ward room, on November 18th, 2015, as it was a bright day and the windows curtains were sheer. Inspector #133 could therefore not obtain additional light level measurements for these areas of concern in ward rooms.

Large dining room: Lighting levels were measured throughout the dining room during the evening, between 5pm and 7pm, on November 17th, 2015. At the time of the inspection, this room was served by seven sets of ceiling mounted troffer lights and a ceiling fan in the center area with three compact fluorescent bulbs in it. At table #3, at resident # 003's seat, the highest level of lighting

measured was 130 lux. At table #8, at the seat closest to the window, the highest level of lighting measured was 140 lux. The ceiling mounted troffer lights in closest proximity to these tables did not serve to adequately illuminate these corner areas.

Bedroom #38 (private): Lighting levels were measured in this bedroom during the evening on November 17th, 2015, between 5pm and 7pm, and again on November 18th, 2015, during the daytime, between 10:30am and 2pm. Directly under the entrance light, the highest level of lighting measured was 142 lux. At the wall that separates the entrance vestibule from the bed area, in the centre, the highest level of lighting measured was 113 lux. At the edge of the resident's dresser (edge closest to the entrance vestibule), before the bed, the highest level of lighting measured was 120 lux. Between the bed and the closet, the highest level of lighting measured was 176 lux. In front of the brown comfortable easy chair, towards the back right corner of the room, the highest level of lighting measured was 135 lux. The entrance light did not serve to adequately illuminate the entrance vestibule area, nor did the troffer light above the bed serve to adequately illuminate all areas of the bed space.

Bedroom #40 (private): Lighting levels were measured in this bedroom during the evening on November 17th, 2015, between 5pm and 7pm, and again on November 18th, 2015, during the daytime, between 10:30am and 2pm. Directly under the entrance light, the highest level of lighting measured was 165 lux. Directly in front of the dresser, within the entrance vestibule, the highest level of lighting measured was 150 lux. At the wall the separates the entrance vestibule from the bed area, in the centre, the highest level of lighting measured was 122 lux. Between the bed and the closet, the highest level of lighting measured was 175 lux. Towards the back right corner, in front of the comfortable easy chair which was next to the television, the highest level of lighting measured was 165 lux. Towards the back left corner, in front of the comfortable easy chair which was next to the small table with pictures on it, the highest level of lighting measured was 130 lux. Between that chair and the side of the bed, the highest level of lighting measured was 153 lux. The entrance light did not serve to adequately illuminate the entrance vestibule area, nor did the troffer lights above the bed serve to adequately illuminate all areas of the bed space.

Bedroom #23 (semi-private): Lighting levels were measured throughout this bedroom during the evening, between 5pm and 7pm, on November 17th, 2015. The influence of natural light prevented light level measurements in this

bedroom during the daytime, on November 18th, 2015. Directly under the entrance light, in the immediate area of resident #001's closet, the highest level of lighting measured was 169 lux. Between bed #1 and the side wall, in front of the chair next to the bed side table, the highest level of lighting measured was 175 lux. The entrance light did not serve to adequately illuminate the entrance vestibule area, nor did the troffer lights serve to adequately illuminate all areas around bed #1.

Spa room: Lighting levels were measured throughout this room during the evening on November 17th, 2015, between 5pm and 7pm, and again on November 18th, 2015, during the daytime, between 10:30am and 2pm. There were no windows in this room. In the center of the shower stall, with the spa room door closed and with the shower curtain closed, the highest level of lighting measured was 60 lux. With the shower curtain open, facing outwards, the highest level of lighting measured was 104 lux. The shower stall was equipped with a circular ceiling mounted fixture and the area directly outside of the shower stall was served by a set of troffer lights.

Bedroom #41 (private): Lighting levels were measured throughout this bedroom on November 18th, 2015, between 11:20am and 2pm. In addition to previously referenced bedroom lighting, this bedroom was also served by a wall mounted fixture, to the right of the bed (when facing the bed). Directly under the entrance light, in front of the resident's closet, the highest level of lighting measured was 141 lux. In front of the brown reclining chair in the corner, the highest level of lighting measured was 135 lux. The entrance light did not serve to adequately illuminate the entrance vestibule area, nor did the troffer lights above the bed serve to adequately illuminate the corner area.

Bedroom #24 (semi-private): Lighting levels were measured throughout this bedroom on November 18th, 2015, between 11:20am and 2pm. Directly under the entrance light, the highest level of lighting measured was 173 lux. In front of the closet for bed #1, the highest level of lighting measured was 183 lux. The entrance light did not serve to adequately illuminate the entrance vestibule area, nor did the troffer lights serve to adequately illuminate all areas around bed #1.

Bedroom #22 (semi-private): Lighting levels were measured throughout this bedroom on November 18th, 2015, between 11:20am and 2pm. Directly under the entrance light, the highest level of lighting measured was 186 lux. In front of resident # 006's closet, the highest level of lighting measured was 179 lux. The

entrance light did not serve to adequately illuminate the entrance vestibule area, nor did the troffer lights serve to adequately illuminate all areas around bed #1.

Bedroom #29 (semi-private): Lighting levels were measured throughout this bedroom on November 18th, 2015, between 11:20am and 2pm. Directly under the entrance light, the highest level of lighting measured was 177 lux. In front of resident #007's closet, the highest level of lighting measured was 178 lux. The entrance light did not serve to adequately illuminate the entrance vestibule area, nor did the troffer lights serve to adequately illuminate all areas around bed #1.

It was noted by inspector #133 that some of the non-compliance observed in some semi-private and private resident rooms, as opposed to the ward rooms, was due to the distance between entrance light and the troffer lights within the bed areas. In the ward rooms, the troffer lights were approximately four feet from the entrance light. Consequently, in these rooms, the troffer lights added illumination to the entrance vestibule area and to the space between the first beds and the walls, on both sides of the room. In the semi-private rooms, the troffer lights were approximately nine feet from the entrance vestibule light. In these rooms, the troffer lights did not add illumination to the entrance vestibule and added less illumination to the space between bed #1 and side wall. In private rooms, the troffer lights were also approximately 9 feet from the entrance vestibule light. In these rooms, the troffer lights did not add illumination to the entrance vestibule and added less illumination to the space between the bed and the side wall, where the closet was typically located. In addition, in the private rooms, the troffer lights did not adequately illuminate the corners areas of the rooms, where the comfortable easy chair(s) were typically located.

The minimum required amount of 215.28 lux was not achieved in all areas of the home, as specifically identified above. This continuing pattern of non-compliance requires that the Compliance Order be reissued. Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents. Insufficient lighting may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents, including to conduct assessments and to provide treatments. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility, nutritional intake, and overall quality of life. (133)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 12th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE

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