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**
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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 16, 2014 | 2014_365194_0004 | O-000446-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

**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**

CHANTAL LAFRENIERE (194), KELLY BURNS (554), SAMI JAROUR (570), WENDY BERRY (102)

**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): May 26,27,28,29,30,31 June 02,03,04 & 05, 2014**

**During the course of this inspection a concurrent Complaint Log# O-000068-14 and a Critical Log# O-000332-14 was completed.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), RAI coordinator, Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), Dietitian(DA), Physio Therapist (PT), Physio Therapist Aides (PTA),Nutritional Care Manager/Environmental Service Supervisor NCM/ESM, Maintenance person, Dietary Aides, Life Enrichment Aide (LA), Office Manager, Families, Residents, Community Care Access Center (CCAC)and Public Guardian and Trustee (PGT).**

**During the course of the inspection, the inspector(s) completed an initial tour of the building, observed resident's living areas, dining service, medication administration, infection control practices, resident/staff interaction and provision of care. Reviewed licensee's policy related to infection control, medication, prevention of abuse, skin/wound care and continence management. Reviewed clinical health records for identified residents, reviewed meeting minutes Resident Council, reviewed trust account records, education record and maintenance records.**

**The following Inspection Protocols were used during this inspection:**

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

Findings of Non-Compliance were found during this inspection.

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:**
**1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).**

**s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:**
**3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).**

**Findings/Faits saillants :**

1. Residents #11,10,02,990,950 and 648 have no documented evidence that screening for Tuberculosis has been completed.

DOC has confirmed that the home was having issues with the vaccine fridge earlier this year and resident's requiring vaccines did not get them.

The licensee's policy IF-3.16 dated January 2014 "Infection control standards for Tuberculosis testing" directs;
-A registered staff will obtain an order for a chest x-ray (posterior-anterior and lateral) to be taken for the resident who does not have a chest x-ray within 90 days prior to admission. The new chest x-ray needs to be scheduled within 14 days after admission.

Review of the homes "admission physician's order" check list states "two step mantoux if needed", there is no mention of chest X-rays. RN # 108 and RN # 123 were unfamiliar with the home's current practices related to the screening of residents for Tuberculosis.

Residents have been admitted to the home and have not been screened for Tuberculosis. At the time of the inspection there was no active plan to have the screening completed. The health and safety of the resident's in the home are at an increased risk to the exposure of communicable diseases. [s. 229. (10) 1.]

***Additional Required Actions:***

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

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**WN #2: 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**

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**Findings/Faits saillants :**

1. During the inspection by Inspector # 102 on June 02 and 03, 2014, lighting levels were checked using a hand held light meter. In all areas checked, the light meter was held 3 to 4 feet above the floor surface, with all available light fixtures turned on and time allowed for fixtures to fully illuminate. Window coverings were closed in bedrooms and common areas.

Minimum levels of 215.28 lux of continuous consistent lighting was not provided throughout all corridors. The measured lighting levels were identified as follows:
-less than 50% of the required level throughout the majority of the corridor that is illuminated by pot light fixtures in the vicinity of the nursing station;
-less than 50% of the required level between florescent ceiling fixtures to exceeding 215.28 lux below and in close proximity to the fixtures in all other main floor resident accessible corridors.

Minimum levels of 215.28 lux are not provided in the the following areas:
-the central lounge, illumination levels were less than 50 % of the requirement in the majority of the lounge space
-in the majority of residents' bedrooms, illumination levels were less that 50% to 75% of required levels unless in close proximity to the provided ceiling light fixtures.
-in the vicinity of the therapeutic tub and within the shower stall in bathing room # 32, ilumination levels ranged from less than 50 % to 75%.

Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments; to conduct assessments; 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 # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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Findings/Faits saillants :

1. All resident accessible doors leading from corridors to non secure areas outside of the home are equipped with an audible door alarm that is connected to an "Esprit" numerical keypad with an audio enunciator at the nurses' station. Audible alarms for the doors are canceled at the keypad within the nurses' station.

The doors are not equipped with an audible door alarm that allows calls to be canceled only at the point of activation.

The doors are not connected to the resident-staff communication and response system or to an audio visual enunciator at the nurses' station and a manual reset switch for enunciator at each door.

The keypad provided at each door is connected to the door locking system only.

The safety, security and well being of residents is potentially at risk. Staff are not able to identify which exit door has triggered an audible alarm and do not have to go to the doors to cancel an alarm at the audio enunciator. [s. 9. (1)]

***Additional Required Actions:***

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

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**WN #4: 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,**
**(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg. 79/10, s. 51(2)(b), by ensuring each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented

Toileting plans and routines were observed, for resident's using room 24, which the home indicated is used as a communal toileting room. The following residents requested toileting and waited the following times:
- Resident #004 - 35min
- Resident #614 - 17min
- Resident #628 - 27min
- Resident #657 - 38min

All residents indicated above require two staff to assist with toileting and are toileted on days and evenings using room twenty four; residents above are toileted using a bed pan or are provided with pads or briefs for containment during the night.

Resident #628 confirmed incontinence episodes occasionally due to waiting so long to use room 24.

Resident #614 expressed concerns related to long wait times related to toileting in room 24.

RAI-Clinical Coordinator, on May 30th, indicated that it requires two staff to transfer residents on and off the commode or toilet due to mechanical lifts and that room 24 is used due to staffing limitations as only two staff are on the unit due to break time and that the communal toileting room is used as the home only has four commodes to toilet residents. RAI-CC provided a list indicating that 14/43 residents are toileted in room 24.

Staff #107 and 108, indicated that room 24 is used for resident toileting as the mechanical lifts will not fit into resident individual washrooms.

Family Member #202, indicated that her loved one (Resident #657) waited 50 min to be toileted in room 24, after supper on an identified date.

The current care plans for the above residents indicate that all have some bladder control; the care plan directs that staff respond to requests for toileting as soon as possible to avoid or reduce incontinence episodes. [s. 51. (2) (b)]

***Additional Required Actions:***

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

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

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

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**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007, c. 8, s. 6(7) by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #950 was admitted to the home and identified as having a "medium" nutritional risk.

The Registered Dietitian (RD), indicated that Resident #950's weight was below the healthy range of 49-54kg (BMI 19-21). The RD wrote orders for Resource 2.0 60mL QID with medication pass and Ensure Plus 235mL at meals if intake is 25% or less.

The written care plan for this resident did confirm the use of nutritional supplements (Resource and Ensure Plus) as interventions.

The Dietitian reassessed the resident, three months later, and ordered Ensure Plus 125mL at breakfast and lunch in addition to the above orders.

A review of food and fluid intake records for this resident indicated that the resident consumed 25% or less during the following time periods:
- identified month in 2014 – five times indicated
- a month prior – five times indicated
- a month prior – thirteen times indicated with 4 meal refusals
- a month prior – eighteen times indicated with 2 meal refusals

Food and Fluids records for the above period indicated that Resident #950 consistently refused both afternoon and evening snack.

Medication Administration Records (MAR) and Intake Monitoring Records for the period of five months, failed to demonstrate the Ensure Plus 235mL was provided to Resident #950 when meal intake was 25% or less, as ordered by the Registered Dietitian and Attending Physician.

The Nutritional Care Manager, indicated that the dietary department was not responsible to provide the resident's Ensure Plus and communicated that such was the responsibility of the nursing department.

Staff #110, who administers the medication, indicated no awareness of the medication nurse being responsible to provide the 'as needed' Ensure Plus, despite the order being on the Medication Administration Record (MAR).

The Director of Care indicated the home had recently changed service providers relating to the nutritional supplements and that there appeared to be some miscommunication as to which department was responsible for administering the nutritional supplements. DOC indicated that on a go forward basis, registered nursing staff will take on this responsibility.

The resident's weight records indicated a weight loss of 10% in 180 days. [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 by ensuring that care set out in the plan of care for residents with nutritional supplements will be provided as specified in the plan, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007, c.8, s.15(2)(a) by ensuring that the home, furnishings and equipment are kept clean and sanitary.

The following were observed May 26, 29 and May 30, 2014

- Dark brown staining was observed around the toilet base sealant in rooms #24, 45, 47, 49, 51, 52, 53, 60, 61, 62, 63, and 64.

- The flooring in resident rooms (#47, 49, 53, 60, 61, 62) and adjoining washrooms were observed visibly soiled with dark coloured dust particles and brown-grey wax-like build up along the wall baseboard/wall guard in these areas, as well as along doorway threshold leading into the washroom. The wax-like build up along the doorway threshold of the resident washrooms was easily scraped off.

- Dried brown/black staining was observed along the back inner aspect of the raised toilet seats in rooms #49, 64 and 63. Dried brown staining was observed around the front outside of the raised seat in room #62; these toilets had just been cleaned by housekeeping staff.

- The falls prevention mats in resident room's #40(x2), 49, 52, and 60 were visibly soiled with white film and dried white spots.

- The mechanical lifts (Sara 300 and another sit to stand lift) were visibly soiled along the leg frames, foot and knee rests.

Staff #115, on May 30, 2014 indicated the flooring in the resident rooms and washrooms should be dry and wet mopped daily, but there are other priorities that arise and often the floors are just spot cleaned as needed.

The Environmental Services Manager (ESM), on May 30, 2014 was not aware of the floor washing schedules or if the floors in resident rooms or washrooms were cleaned daily; ESM did agree that the floors were visibly soiled and that the raised toilet seats should be cleaned at the same time as the toilet. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007, c.8, s. 15(2)(c) by ensuring that the home, furnishings and equipment are maintained in a safe condition and a good state of repair which is a potential risk to the health, safety and well-being of residents. The following areas were identified:

Flooring:

- The laminate flooring in the shower stall was observed cracked along the bottom parameter where the walls and flooring join, exposing the subflooring which was damp. The vinyl flooring in the remainder of the tub/shower room was also cracked in several locations throughout the room.

- The laminate flooring in the washroom of room #60, had an area of approximately 30cm length x 5cm width, were the flooring had separated from the wall/wall guard; visible soiling could be seen on the exposed subflooring. This washroom was noted on May 26 through to May 30th to have a strong, urine-like odour.

Non intact surfaces cannot be effectively cleaned and sanitized or disinfected as needed presenting a potential infection prevention and control risk.

Equipment:
- Room #49 – grab bar along the wall by the toilet was observed to be rusty
- Room #24 – an off-white colour commode was observed to have rust on all four wheels and along the circular frame which houses the commode pot; the same commode's vinyl backrest was cracked and had foam exposed
- The legs (steel frame) of the Sara 300 mechanical lift were visibly rusty
- Two commode chairs were noted in room 24. The breaks on both commode chairs when placed in the locked position did not prevent the chair from moving, making the chair unsafe for use
- The finish inside the tub is chipped in two areas, which poses a potential infection control issue

Other:
- The baseboard heaters in rooms #40, 46, 47, 49, 50, 51, 61, 62, 63 and 64 were observed scuffed and or rusty
- Room #24 – the metal legs of the sink frame were rusty
- The walls in room #64(washroom), #63D (bedroom), and #50 had minor wall damage or evidence of wall repair unfinished
-Room #61 – wall directly under the window was cracked and the wall was visible bulging approximately 20cm in length
- Room #63D – phone jack cover was missing

A review of the Maintenance Log Repair Binder for the period of February 12 through to May 30, 2014, did not identify any of the above maintenance concerns.

The Housekeeping and Preventative Maintenance audits for the period of May 2014 did not identify any of the indicated areas requiring repair or maintenance.

The Environmental Services Manager, on May 30th indicated awareness of the flooring problem in the tub/shower room, but wasn't aware of the other identified issues. ESM indicated no awareness of plans to resolve flooring issues in the tub/shower room.

On May 28, 2014 it was observed by inspector #194 that the brakes of Resident #990's walker were not working.

The inspector was informed by Administrator and RPN #101 that the practice at the home for equipment noted to need repair is as follows;
-the staff who identifies any concerns would place the information in the binder " Shopper Home Health Care Service repair log" at the nursing station
-The service provider will review binder when he is in the home and address the repairs and signs off that the repairs have been completed.

RPN #101 stated she would complete the form in the service log for Resident #990's walker to insure repairs. [s. 15. (2) (c)]

***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 by ensuring that the home, furnishing and equipment are kept clean, sanitary, in a safe condition and in a good state of repair., to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids**

**Specifically failed to comply with the following:**

**s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,**
**(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).**
**(b) cleaned as required. O. Reg. 79/10, s. 37 (1).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg. 79/10, s. 37 (1), by ensuring that each resident of the home has his or her personal items, including personal aids labelled.

The following was observed on May 26, 2014:

- Tub/Shower Room – 3 brushes were found in a white bin in this room; hair of different colours were visible in the brushes. In the same bin, two nail clippers were observed. Items listed above were not labelled for individual resident use.

Personal Support Worker, assigned to baths on May 26, 2014, indicated that personal grooming supplies are to be labelled for individual resident use. [s. 37. (1) (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 by ensuring that each resident of the home has his or her personal items labelled., to be implemented voluntarily.***

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**WN #8: 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).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg 79/10 s. 50(2)(b)(iv) when resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears and wounds, were not reassessed at least weekly by a member of the registered nursing staff

Interview with DOC confirmed that currently weekly assessments of wounds are documented by the Registered staff in the resident's clinical health record in the computer.

The clinical health record for Resident #654 in the Treatment Administration Records (TARS) for the period of two months confirm that the resident was being treated for wounds requiring dressings.

The Resident's clinical health record provides for three weekly wounds assessments for the period of six weeks.

Interview with RN #108 confirms the home practice in November and December 2013 for assessments of wounds was the completion of the "Treatment and Observation Record" weekly.

The plan of care for Resident #649 directs weekly assessment be completed for the wound on the Treatment sheets.

Review of the TARS for resident #649 for the period of two months confirm that the resident was being provided treatment for a wound.

Review of the clinical health records provides two weekly assessment for the period of five weeks. [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 by ensuring that residents 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.***

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 86. (2) The infection prevention and control program must include,**
**(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).**
**(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007 s. 86(2)(b) when measures where not in place to prevent the transmission of infections

RPN#101 has confirmed that staff are using room 24 as a common washroom for a number of resident's in the home.
-the call bell in room 24 near the toilet has "corded texture" which is not a readily cleanable cord.
-this room is also used as a storage area for items such as Christmas decorations stored on open shelves behind the commode chairs, posing as a cross contamination risk.
-The commode chairs are stored directly beside the toilet with commode chair arms within close proximity of any resident being seated on the toilet, posing as a cross contamination risk.
-hygiene supplies such as toothetts, mouthwash, manicure sticks were noted in an open caddy, stored in an open shelving unit in the toileting area of room 24, posing a cross contamination risk.
- A bed pan was observed sitting on the back of the toilet in room #39A; this is a shared resident washroom.
On June 3, 2014 it was observed that there was an unlabelled urinal and bed pan in room 24 which is used as a toileting room for a number of residents' in the home.

- in the soiled utility room, clean supplies were stored on open shelves in close proximity to the flusher (sluice/hopper) which is equipped with a sprayer. Clean plastic ware (basins, etc), hand hygiene products and perineal irrigation bottles were stored on open shelving in close proximity to the flusher; liquid oxygen base cryogenic refill units were stored across from the flusher. Oxygen decanting is done within the soiled utility room.
-in the hair salon, 10 shared use combs were left immersed in a visibly soiled disinfecting solution located in a glass container. Instructions for use of the disinfecting solution are not been followed; 3 communal use electrical clippers were in a visibly soiled state. A communal use wax applicator kit labeled as " "Clean and Easy Petite Waxing Spa" was set up and available for use on the counter in the hair salon.
- several torn, worn and soiled or stained foam type arm rests were attached to toilet safety frames in use on a number of shared use toilets in ensuite washrooms. The absorbent foam type surfaces are not able to be cleaned and disinfected. [s. 86. (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 by ensuring that measures are in place to prevent the transmission of infection, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg 79/10 s. 131(2) when drugs were not administered to residents in accordance with the directions for use specified by the prescriber.

A consent was signed by Resident #79's POA on admission for the administration of pneumovax vaccine. A physician's order was received for the administration of pneumovax vaccine on admission. Resident #079 did not receive a pneumovax vaccine.

A consent was signed by Resident #01's POA on admission for the administration of pneumovax vaccine. A physician's order was received for the administration of pneumovax vaccine on admission. Resident #01 did not receive a pneumovax vaccine.

A consent was signed by Resident #905's POA on admission for the administration of pneumovax vaccine. A physician order was received on admission for the administration of pneumovax vaccine. Resident #950 did not receive a pneumovax vaccine.

DOC has confirmed that the home was experiencing problems with their vaccine fridge at the beginning of the year and resident's that required vaccines did not get them. [s. 131. (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 by ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber., to be implemented voluntarily.***

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.**

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA 2007 s.14 when every resident shower did not have at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

The residents' shower located in bathing room #32 is not equipped with grab bars. [s. 14.]

**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**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 comply with O.Reg 79/10 s. 71(4) when planned menu items were not offered

On June 3, 2014 PSW's # 117, #118, #119, #120 and Dietary Aide (DA) #121 confirmed that Resident's #03,#05,#08, #09,#626 who were in isolation and Residents #625, #690 who were being provided lunch in their bedrooms were not offered the planned menu items identified for the lunch meal. DA #121 stated that she prepared the trays according to her knowledge of the resident's likes and dislikes. [s. 71. (4)]

**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

**Specifically failed to comply with the following:**

**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,**
**(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).**

**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg 79/10 s. 72(3)(b) when food and fluids were not prepared, stored and served using methods which prevent adulteration, contamination and food borne illness.

On an identified date a serving cart carrying 4 trays for isolated resident's was noted in the hallway outside of room #62. The food trays were observed to have uncovered drinks, deserts and soup. The cart was sitting in the hallway, while residents were making there way back from the lunch meal during a respiratory outbreak. [s. 72. (3) (b)]

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal**

**Specifically failed to comply with the following:**

**s. 136. (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:**
**1. The date of removal of the drug from the drug storage area. O. Reg. 79/10, s. 136 (4).**
**2. The name of the resident for whom the drug was prescribed, where applicable. O. Reg. 79/10, s. 136 (4).**
**3. The prescription number of the drug, where applicable. O. Reg. 79/10, s. 136 (4).**
**4. The drug's name, strength and quantity. O. Reg. 79/10, s. 136 (4).**
**5. The reason for destruction. O. Reg. 79/10, s. 136 (4).**
**6. The date when the drug was destroyed. O. Reg. 79/10, s. 136 (4).**
**7. The names of the members of the team who destroyed the drug. O. Reg. 79/10, s. 136 (4).**
**8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg. 79/10, s. 136 (4), by ensuring that where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy provides the applicable documentation.

The Director of Care indicated that the drug destruction and disposal of controlled substances and narcotics was last completed April 16, 2014, by a team consisting of DOC and Pharmacy Consultant.

During a review of the drug destruction records for the period of indicated above, the DOC provided four pages of resident medications listed on a sheet labeled 'surplus medication drug sheet' dates of individual medications on the sheets were dated December 18, 2013 through to March 04, 2014; the sheets were initialed by two unknown individuals on April 16, 2014. The DOC indicated that the initials belonged to herself and the Pharmacy Consultant.

The sheet used by the home for drug destruction and disposal does not identify the following required information:
- reason for destruction
- and the manner in which the drug was destroyed [s. 136. (4)]

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident**

**Specifically failed to comply with the following:**

**s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,**
**(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).**
**(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).**
**(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).**
**(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).**

**Findings/Faits saillants :**

1. Related to Log #O-0000068-14, for Resident #007:

The licensee failed to comply with O. Reg. 79/10, s. 148 (2)(c), by ensuring that before discharging a resident under subsection 145 (1), the licensee shall ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration.

The Administrator indicated that the Resident #007 was admitted under the Public Guardian and Trustee and had no Next of Kin.

Administrator indicated the home formally discharged Resident #007 as the home was unable to manage resident's behaviours, despite numerous attempts.

A letter, from the licensee, was forwarded by mail to the following CCAC, Community Living (Case Worker), Ministry of Health and Long Term Care, with regards to the resident's discharge, with an explanation outlining the reasons for the discharge.

The Public Guardian and Trustee (PGT) indicated that they did not know of the resident's discharge from Burnbrae Gardens until they were notified by Community Care Access Centre (CCAC). PGT indicated they should have been contacted by the home with regards to all care decisions pertaining to Resident #007.

The licensee failed to provide notification of Resident #007's discharge to the Public Guardian and Trustee, who was responsible for all care decisions relating to this resident. [s. 148. (2) (c)]

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**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts**

**Specifically failed to comply with the following:**

**s. 241. (7) The licensee shall,**
**(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).**

**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg. 79/10, s.241. (7)(f), by ensuring that a quarterly itemized statement is provided to the resident, or to a person acting on behalf of a resident respecting money held by the licensee in trust for a resident.

The Office Manager, on June 2, 2014, indicated the home held funds in trust for the following four individual's, Resident #001, 622, 655, and 950.

A review of the individual financial records for Resident's #622 and #655 indicated that the home is keeping records of account activity (deposits and withdrawals) in separate ledgers for each resident.

Office Manager indicated that residents and or their Power of Attorney for Property are not provided quarterly itemized statements.

The home's Trust Account policy, dated March 2001, directs that a statement of all transactions will be provided to the resident and or their Power of Attorney for Property regularly on a quarterly basis.

The home is aware of the requirement and on a go forward basis will provide itemized statements on a quarterly basis. [s. 241. (7) (f)]

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**

**Issued on this 16th day of June, 2014**

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

C Lafrenière (#194)

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) :** | CHANTAL LAFRENIERE (194), KELLY BURNS (554), SAMI JAROUR (570), WENDY BERRY (102) |
| **Inspection No. / No de l'inspection :** | 2014_365194_0004 |
| **Log No. / Registre no:** | O-000446-14 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Jun 16, 2014 |
| **Licensee / Titulaire de permis :** | OMNI HEALTH CARE LIMITED PARTNERSHIP<br>1840 LANSDOWNE STREET WEST, UNIT 12,<br>PETERBOROUGH, ON, K9K-2M9 |
| **LTC Home / Foyer de SLD :** | BURNBRAE GARDENS LONG TERM CARE RESIDENCE<br>320 BURNBRAE ROAD EAST, P.O. BOX 1090,<br>CAMPBELLFORD, ON, K0L-1L0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | SUSAN CYMBALUK |

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

To OMNI HEALTH CARE LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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**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. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

O. Reg. 79/10, s. 229 (10).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that each resident admitted to the home is screened for tuberculosis.

The plan shall include:
- screening for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening is available to the licensee.
-screening for tuberculosis of admitted residents listed below to determine the risk of infection.

The licensee will provide a written plan by June 23, 2014.

This plan must be submitted in writing to the MOHLTC, Attention: Chantal Lafreniere, Fax (613)569-9670.

**Grounds / Motifs :**

1. Residents #11,10, 02, 990, 950 and 648 have no documented evidence that screening for Tuberculosis has been completed.

DOC has confirmed that the home was having issues with the vaccine fridge earlier this year and resident's requiring vaccines did not get them.

The licensee's policy IF-3.16 dated January 2014 "Infection control standards for Tuberculosis testing" directs;
-A registered staff will obtain an order for a chest x-ray (posterior-anterior and lateral) to be taken for the resident who does not have a chest x-ray within 90 days prior to admission. The new chest x-ray needs to be scheduled within 14 days after admission.

Review of the homes "admission physician's order" check list states "two step mantoux if needed", there is no mention of chest X-rays. RN # 108 and RN # 123 were unfamiliar with the home's current practices related to the screening of residents for Tuberculosis.

Residents have been admitted to the home and have not been screened for Tuberculosis. At the time of the inspection there was no active plan to have the screening completed. The health and safety of the resident's in the home are at an increased risk to the exposure of communicable diseases.

(194)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 30, 2014

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

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**Order # / Ordre no :** 002

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

**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 :**

The licensee will ensure that required levels of lighting are provided in all areas of the long term care home including:

- A minimum of 215.28 lux of continuous consistent lighting in corridors;
- A minimum level of 215.28 lux in all residents' bedrooms, program/lounge space, tub and shower rooms.

The licensee will provide a written progress report indicating the status of the lighting levels by November 1, 2014.

This progress report must be submitted in writing to the MOHLTC, Attention: Wendy Berry, Fax (613)569-9670

**Grounds / Motifs :**

1. During the inspection by Inspector # 102 on June 02 and 03, 2014, lighting levels were checked using a hand held light meter. In all areas checked, the light meter was held 3 to 4 feet above the floor surface, with all available light fixtures turned on and time allowed for fixtures to fully illuminate. Window coverings were closed in bedrooms and common areas.

Minimum levels of 215.28 lux of continuous consistent lighting was not provided throughout all corridors. The measured lighting levels were identified as follows:
-less than 50% of the required level throughout the majority of the corridor that is illuminated by pot light fixtures in the vicinity of the nursing station;
-less than 50% of the required level between florescent ceiling fixtures to exceeding 215.28 lux below and in close proximity to the fixtures in all other main floor resident accessible corridors.

Minimum levels of 215.28 lux are not provided in the the following areas:
-the central lounge, illumination levels were less than 50 % of the requirement in the majority of the lounge space
-in the majority of residents' bedrooms, illumination levels were less that 50% to 75% of required levels unless in close proximity to the provided ceiling light fixtures.
-in the vicinity of the therapeutic tub and within the shower stall in bathing room # 32, ilumination levels ranged from less than 50 % to 75%.

Low levels of lighting are a potential risk to the health, comfort, safety and well being of residents. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments; to conduct assessments; 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.

(102)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 30, 2015

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Order # / Ordre no :** 003

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

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

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

**Order / Ordre :**

The licensee will ensure that all resident accessible doors leading to the outside are:
- Equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
- Is connected to the resident-staff communication and response system or, is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

**Grounds / Motifs :**

1. All resident accessible doors leading from corridors to non secure areas outside of the home are equipped with an audible door alarm that is connected to an "Esprit" numerical keypad with an audio enunciator at the nurses' station. Audible alarms for the doors are canceled at the keypad within the nurses' station.

The doors are not equipped with an audible door alarm that allows calls to be canceled only at the point of activation.

The doors are not connected to the resident-staff communication and response system or to an audio visual enunciator at the nurses' station and a manual reset switch for enunciator at each door.

The keypad provided at each door is connected to the door locking system only.

The safety, security and well being of residents is potentially at risk. Staff are not able to identify which exit door has triggered an audible alarm and do not have to go to the doors to cancel an alarm at the audio enunciator.

(102)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 30, 2014

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Order # / Ordre no :** 004

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

**Order / Ordre :**

The licensee shall ensure that resident's assessed continence needs are implemented to promote and maintain resident's ability to remain continent respecting the resident's comfort and dignity

- Through an individualized plan for each resident who is incontinent to promote and manage bowel and bladder continence based on the assessment and implementation of that plan .
-Through an assessments to determine any equipment required to enable resident's to be toileted in accordance to their needs
-Through an environment that promotes the resident's comfort and dignity
- Through a review of staff accessibility to commodes for the provision of continence care
- Through a system to monitor that individual care plans are implemented on all shifts

This order relates to residents being toileted in room 24

**Grounds / Motifs :**

1. Toileting plans and routines were observed for resident's using room 24, which the home indicated is used as a communal toileting room. The following residents requested toileting and waited the following times:
- Resident #004 - 35min
- Resident #614 - 17min
- Resident #628 - 27min
- Resident #657 - 38min

All residents indicated above require two staff to assist with toileting and are toileted on days and evenings using room twenty four; residents above are toileted using a bed pan or are provided with pads or briefs for containment during the night.

Resident #628 confirmed occassional episodes of incontinence due to waiting so long to to be toileted.

Resident #614 expressed concerns of being uncomfortable and frustrated related to the delays for continence care.

RAI-Clinical Coordinator, on May 30th, indicated that it requires two staff to transfer residents with the mechanical lift on and off the commode or toilet in

room 24. The RAI-CC further directed that room 24 is used due to staffing limitations; only two staff are on the unit due to staff break. The communal toileting room is used as the home only has four commodes to toilet residents. RAI-CC provided a list indicating that 14/43 residents are toileted in room 24.

Staff #107 and 108, indicated that room 24 is used for resident toileting as the mechanical lifts will not fit into resident's individual washrooms.

Family member #202, indicated that her loved one (Resident #657) waited 50 min to be toileted in room 24, after supper on an identified date.

The current care plans for Resident's # 004,614,628 and 657 indicate that all have some bladder control; the care plan directs that staff respond to requests for toileting as soon as possible to avoid or reduce incontinent episodes.

Review of the Residents' Council minutes confirm that the resident's have complained about the wait times for continence care in room 24.
The Administrator responded to the complaint stating that the Charge RN on each shift was to monitor and ensure that toileting happens in a timely fashion.

Interview and observations of residents during the Resident Quality Inspection (RQI) confirms that continence care concerns such as comfort, dignity and promotion of resident's continence in room 24 continue to be an issue.
(194)

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

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.

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

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 16th day of June, 2014**

**Signature of Inspector / Signature de l'inspecteur :** C Lafreniere (194)

**Name of Inspector / Nom de l'inspecteur :** Chantal Lafreniere

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