Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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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
Feb 17, 2017;	2016_327570_0021 (A1)	002610-16	Follow up

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

SAMI JAROUR (570) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested an extension of the compliance date to April 30, 2017.

Issued on this 17 day of February 2017 (A1)

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

Original report signed by the inspector.

Ontario

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

SAMI JAROUR (570) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 04-07, 2016 and October 11, 2016

Follow up inspection Log #002610-16 related to compliance order #005 issued under inspection #2015_365194_0028 regarding the home, furnishings and equipment not maintained in a safe condition and in a good state of repair with a compliance date of July 31, 2016.

During the course of the inspection, the inspector(s) spoke with Administrator, the licensee`s Regional Director, Director of Care (DOC), Residents, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nurse Administrative Assistant, Environmental Services Supervisor (ESS), Housekeeping staff and the Pharmacist.

During the course of this inspection, the inspector toured the home, observed staff to residents interactions and provision of care; reviewed clinical health records of identified resident, relevant policies, housekeeping and maintenance audit records, staff educational records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Medication

Safe and Secure Home

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

3 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

As a result of the Resident Quality inspection (RQI) #2015_365194_0028 conducted in November 2015, the licensee was served with a Compliance Order (#005) on January 31, 2016 with an initial compliance date of April 30, 2016. The licensee requested an extension to July 31, 2016 which was agreed upon. The licensee was ordered to ensure that a monitoring process is in place to assess the effectiveness of the housekeeping and maintenance practices in the home. The monitoring process will include a method:
-to ensure that the "deep cleaning policies and practices for the home are implemented and complied with.
-to ensure that re-education is provided, to all departments related to the process for "PM Works", which is the electronic Maintenance requisitions used in the home
-to ensure that the ESM is conducting weekly audits related the home furnishings and equipment being kept clean, sanitary, safe and in a good state of repair.
-Monthly analysis of all PM works received, is completed to identify and address any deficiencies.

During this follow up inspection, the following observations were made, during the period of October 4-6, 2016:

Linden unit:
- TV Lounge area: scraped paint with water damage to window sill with wood exposed; damaged flooring (gouged and cracked with black marks noted) around

the middle of the TV lounge area.
- Tub/Shower room: Lower wall damage to wall tiles at corners in three areas;
- In an identified resident's room: ripped laminate flooring in bathroom (about 10 cm).
- In an identified resident's room: gap between floor and base board with dirt accumulating; new white tiles (3 tiles) installed with no grout; space visible between tiles; broken 2 tiles next to vanity with missing pieces exposing the under surface.
- In an identified resident's room: ripped laminate flooring next to toilet base exposing the under surface; broken tile with missing piece next to window exposing the under surface (corner bead);
- In an identified resident's room: noted missing base board at corner next to bathroom door frame exposing a rusted corner bead.
- In an identified resident's room: scraped paint of lower wall above baseboard.

Birch unit:
- In an identified resident's room: scraped paint of lower wall; dark blackish brown staining surrounding base of toilet and surrounding flooring.
- In an identified resident's room: baseboard is lifting at lower corner next bath room exposing the under surface (corner bead).
- In an identified resident's room: lower door frame is chipped.
- In an identified resident's room: the covering of the lower door of the room is loose and chipped creating sharp edges. Lower door frame guard is chipped with sharp edges noted. Scraped paint of lower bathroom door; the bathroom does not close properly; corners of the door are chipped with wood exposed.
- Dry wall damage to lower wall in hallway across from an identified resident's room.
- Water damage/scraped paint with wood exposed of window sill in hallway next to an identified resident's room.
- In two identified residents' rooms – damage to lower door frame guard.
- Damage to lower wall at corners at patio door with rusted corner bead exposed in Birch TV lounge/activity room.

Maple unit:
- Dry wall damage to corner (mid wall) exposing corner bead next to an identified resident's room.
- Dry wall damage to wall corners at entrance of two identified residents' rooms.
- Scraped paint of lower bathroom door of a resident room; Brown stains with small holes on floor from a previously installed commode chair in bathroom.
- Tub room for Maple and Birch units - brown staining on the floor in tub area; gap

between floor and wall at entrance of shower area exposing the under surface with dirt accumulating; damaged cover of the light switch; brown stain around toilet base in shower area; missing corner guard of short wall in toilet area; lower wall covering is lifting above baseboard; missing piece of baseboard at entrance of shower area exposing the under surface.
- Brown stains on floor in hallway of Maple unit at entrance of main dining room.

Pine unit:
- Missing hand rail (3 meters long) with 4 holes in dry wall at entrance of Pine unit.
- Scraped paint of lower walls (gouged) above baseboard; chipped lower wooden frame at entrance of Pine TV lounge;
- Tub/Bathing area: Drywall damage to lower wall in toilet area exposing corner bead that was noticed dented inwards; brownish/rust like stain around toilet base; Brown/rust stains around shower/tub; damaged lower corner at sitting/tub shower area exposing drywall and rusted corner bead; damaged wall at corners exposing damaged corner beads at tub room entrance; dry wall damage to lower wall between tub room and shower room.
- Scrapped lower wall next to bathroom door of a resident's room.
- Damage to dry wall in hallway with a hole in dry wall about 10x10 cm behind hand railing next to an identified resident's room.
Aspen unit:
- Spa room: broken multiple tiles (lower row) in tub room with gap noted between floor and tile walls (wall with windows); unfinished dry wall repair at entrance of Spa room (not painted); damage to lower wall at baseboard between tub room and shower room; Damage to lower wall at baseboard at entrance of spa room exposing a dented corner bead; Scraped paint of lower door of spa room; dry wall damage to lower wall in hallway at storage door next to Aspen spa room.
- In two identified residents' rooms; door guard / plastic covering of lower wall is loose and lifting creating sharp corners. Missing lower door plastic covering of two residents' rooms (under surface of brown glue is exposed);
- Damage to corner at door frame of the dining room exposing corner bead of lower and mid wall.

On October 05, 2016 the Environmental Services Supervisor (ESS) indicated to the inspector that maintenance staff become aware of areas in need of repair by accessing PM Works (electronic maintenance requisition software) several times a day for repair with anything resident related or high risk area will be fixed within 24 hours.

On October 05, 2016, inspector #570 interviewed the Administrator and the Extendicare Regional Director. The Administrator indicated the preventative maintenance program of the home is included in the PM Works for day to day maintenance schedule and also includes what was scheduled weekly or monthly for preventative maintenance. The Regional Director indicated that the focus was on repairing the deficiencies identified in the MOHLTC inspection report issued in January 2016 and the repairs to those deficiencies were completed. The Administrator further indicated that it is the expectation that all repairs were to be identified and completed; for that a maintenance supervisor was hired in August 2016 so that repairs can be done by maintenance staff if possible and to avoid bringing in contractors unless needed; it was taking too much time for contractors to finish needed repairs; also staff are encouraged to input all needed repairs using the PM works.

On October 05, 2016, during a tour of the Spa room in Pine unit and lounge area in Linden unit with the Regional Director, Administrator and Environmental Services Supervisor (ESS) all indicated that they were not aware of the Pine unit and Linden unit. The regional director indicated to the inspector that the spa room in Pine unit was recently repaired and the damage noted to walls was new. The ESS confirmed to the inspector that none of the damages noted in the Pine spa room and Linden TV lounge were reported to maintenance staff by using the PM Works software. The ESS further indicated that the expectation of the home is that staff will continue to use PM works to communicate needed repairs to the maintenance staff.

The compliance order was served on January 31, 2016 with a compliance date extended until July 31, 2016 required weekly audits and monthly analysis to be completed.
Review of the audits provided to inspector indicated that audits were not completed during the months of April and July 2016 and the audits provided were not completed weekly as required by the compliance order and there were no audits completed for common areas. The resident room sanitation and room repair audits were completed on the following dates during the period of January 31, 2016 to July 31, 2016:
Feb 22, 25, 26; March 8, 11, 17; May 16; June 15 and 21, 2016.

On October 06, 2016 interview with the Administrator and and the ESS both indicated to the inspector that issues identified requiring repair (damaged walls in SPA room in Pine unit) was not communicated to maintenance staff through the

PM Works software; also not all issues identified by inspector were reported in PM works. The Administrator further indicated that she had no evidence that monthly analysis was completed as required by the order and that her expectation was that the former Environmental Services Manager (ESM) but was unable to provide any documentation.

The decision to re issue the compliance order was based on the widespread deficiencies related to the home , furnishings and equipment not being maintained in a safe condition and in a good state of repair identified during this inspection and the licensee's failure to comply with the requirements of the previous compliance order issued in January 2016 under inspection #2015_365194_0028. [s. 15. (2) (c)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 122.(1), by not ensuring that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug:
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

Related to resident #002

On October 11, 2016 at about 1430 hours the following was witnessed by inspector #570:
Resident #002 came to the nursing station on an identified unit and handed a box of prescription drug (controlled substance) to RPN #112. The box was noted to be sealed. Resident #002 told RPN #112 that PSW #113 gave the box to him/her and that he/she was surprised that the box was delivered to him/her.

On October 11, 2016, RPN #112 indicated to the inspector that staff #114 gave the box of a prescription drug (controlled substance) to PSW #113 who gave it to resident #002; later RPN #112 indicated he/she phoned the pharmacy who indicated that the box was sent to the home by a taxi driver with instructions to be delivered to the unit's Charge Nurse. RPN #112 indicated that he/she called the pharmacy for the prescription drug (controlled substance) today and this package should have been delivered to the RPN and if the RPN was not available it should have been delivered to one of the Residents Care Area Managers (RCAM). RPN #112 indicated to the inspector that the package was sealed.

On October 11, 2016 at about 1450 hours during an interview with PSW #113, it was indicated to the inspector that at about 1415 hours, Staff #114 gave him/her a package to be delivered to resident #002 and that he/she was not aware of the content of the package.

On October 11, 2016 at about 1500 hours during an interview with resident #002, it was indicated to the inspector that he/she gets the prescription drug (controlled substance) every 3 days and that the medication helps with pain. The resident also indicted that he/she was aware of the content of the package and that he/she was

concerned if the package had fallen into the wrong hands.

On October 11, 2016 at about 1517 hours during an interview with staff #114 it was indicated to the inspector that a gentleman came to the door and delivered a package to him/her and said, no signature was required when asked. Staff #114 indicated to the inspector no awareness that the package included a prescription drug (controlled substance).

On October 11, 2016 at about 1612 hours during an interview with the home's contracted pharmacist, he indicated to the inspector that he was made aware of the prescription drug (controlled substance) box that was not delivered to Registered Nurse and was not signed off by a Registered Nurse. The pharmacist indicated that the expectations were that the taxi driver should have followed instructions and delivered the package to a Registered Nurse and should have gotten a signature; the nurse has to sign for it and add it to the controlled substances count. The Pharmacist indicated to the inspector that those were the instructions given by the pharmacy to the taxi driver; however, those instructions were not followed by the taxi driver.

The licensee failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident when a package of prescription drug (controlled substance) was delivered to non-registered staff at the home and later delivered to resident #002 before the package was secured by RPN #112. [s. 122. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug:
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario., to be implemented voluntarily.

WN #3: 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 O. Reg. 79/10, s. 14, by not ensuring each resident shower have at least two easily accessible grab bars, one grab bar located on the same wall as the faucet and one grab bar located on the adjacent wall.

On October 04, 2016 during an observation of the bathing areas located at the Pine and Linden units, inspector #570 noted the shower areas in both units did not have a shower grab bar located on the adjacent wall of the faucet.

On October 4, 2016 Personal Support Worker (PSW) #110 indicated to the inspector the shower area in Pine unit was used in the morning to provide showers to residents.

On October 05, 2016 Environmental Services Supervisor (ESS) indicated to the inspector that he was aware that two grab bars are required in shower areas but was not aware that shower grab bars were not installed at the adjacent wall of the faucet in the two identified shower areas. [s. 14.]

Issued on this 17 day of February 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : SAMI JAROUR (570) - (A1)

Inspection No. / No de l'inspection : 2016_327570_0021 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 002610-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Feb 17, 2017;(A1)

Licensee / Titulaire de permis :
CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD :
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Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Angela Rodrigues

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To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, 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: 2015_365194_0028, CO #005;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 15. (2) Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary;

(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

In order to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c), the licensee shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair by implementing the following processes:

1. The licensee shall ensure that staff from all departments document and report any needed repairs to maintenance personnel in a timely manner.

2. The licensee shall ensure that audits are conducted at least monthly to all areas accessible to residents in relation to the home's furnishings and equipment being kept clean, sanitary, safe and in a good state of repair.

3. Corrective action plan must be taken by the licensee to address any deficiencies identified by the audits or reported by staff.

4. The licensee shall ensure that the maintenance program is organized to allow for the ongoing routine, preventative and remedial maintenance needs of the home while focussing on addressing this compliance order.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

As a result of the Resident Quality inspection (RQI) #2015_365194_0028 conducted in November 2015, the licensee was served with a Compliance Order (#005) on January 31, 2016 with an initial compliance date of April 30, 2016. The licensee requested an extension to July 31, 2016 which was agreed upon. The licensee was ordered to ensure that a monitoring process is in place to assess the effectiveness of the housekeeping and maintenance practices in the home. The monitoring process will include a method:
-to ensure that the "deep cleaning policies and practices for the home are implemented and complied with.
-to ensure that re-education is provided, to all departments related to the process for "PM Works", which is the electronic Maintenance requisitions used in the home
-to ensure that the ESM is conducting weekly audits related the home furnishings and equipment being kept clean, sanitary, safe and in a good state of repair.

-Monthly analysis of all PM works received, is completed to identify and address any deficiencies.

During this follow up inspection, the following observations were made, during the period of October 4-6, 2016:

Linden unit:
- TV Lounge area: scraped paint with water damage to window sill with wood exposed; damaged flooring (gouged and cracked with black marks noted) around the middle of the TV lounge area.
- Tub/Shower room: Lower wall damage to wall tiles at corners in three areas;
- In an identified resident's room: ripped laminate flooring in bathroom (about 10 cm).
- In an identified resident's room: gap between floor and base board with dirt accumulating; new white tiles (3 tiles) installed with no grout; space visible between tiles; broken 2 tiles next to vanity with missing pieces exposing the under surface.
- In an identified resident's room: ripped laminate flooring next to toilet base exposing the under surface; broken tile with missing piece next to window exposing the under surface (corner bead);
- In an identified resident's room: noted missing base board at corner next to bathroom door frame exposing a rusted corner bead.
- In an identified resident's room: scraped paint of lower wall above baseboard.

Birch unit:
- In an identified resident's room: scraped paint of lower wall; dark blackish brown staining surrounding base of toilet and surrounding flooring.
- In an identified resident's room: baseboard is lifting at lower corner next bath room exposing the under surface (corner bead).
- In an identified resident's room: lower door frame is chipped.
- In an identified resident's room: the covering of the lower door of the room is loose and chipped creating sharp edges. Lower door frame guard is chipped with sharp edges noted. Scraped paint of lower bathroom door; the bathroom does not close properly; corners of the door are chipped with wood exposed.
- Dry wall damage to lower wall in hallway across from an identified resident's room.
- Water damage/scraped paint with wood exposed of window sill in hallway next to an identified resident's room.
- In two identified residents' rooms – damage to lower door frame guard.
- Damage to lower wall at corners at patio door with rusted corner bead exposed in Birch TV lounge/activity room.

Maple unit:
- Dry wall damage to corner (mid wall) exposing corner bead next to an identified resident's room.
- Dry wall damage to wall corners at entrance of two identified residents' rooms.
- Scraped paint of lower bathroom door of a resident room; Brown stains with small holes on floor from a previously installed commode chair in bathroom.
- Tub room for Maple and Birch units - brown staining on the floor in tub area; gap between floor and wall at entrance of shower area exposing the under surface with dirt accumulating; damaged cover of the light switch; brown stain around toilet base in shower area; missing corner guard of short wall in toilet area; lower wall covering is lifting above baseboard; missing piece of baseboard at entrance of shower area exposing the under surface.
- Brown stains on floor in hallway of Maple unit at entrance of main dining room.

Pine unit:
- Missing hand rail (3 meters long) with 4 holes in dry wall at entrance of Pine unit.
- Scraped paint of lower walls (gouged) above baseboard; chipped lower wooden frame at entrance of Pine TV lounge;
- Tub/Bathing area: Drywall damage to lower wall in toilet area exposing corner bead that was noticed dented inwards; brownish/rust like stain around toilet base; Brown/rust stains around shower/tub; damaged lower corner at sitting/tub shower area exposing drywall and rusted corner bead; damaged wall at corners exposing damaged corner beads at tub room entrance; dry wall damage to lower wall between tub room and shower room.
- Scrapped lower wall next to bathroom door of a resident's room.
- Damage to dry wall in hallway with a hole in dry wall about 10x10 cm behind hand railing next to an identified resident's room.

Aspen unit:
- Spa room: broken multiple tiles (lower row) in tub room with gap noted between floor and tile walls (wall with windows); unfinished dry wall repair at entrance of Spa room (not painted); damage to lower wall at baseboard between tub room and shower room; Damage to lower wall at baseboard at entrance of spa room exposing a dented corner bead; Scraped paint of lower door of spa room; dry wall damage to lower wall in hallway at storage door next to Aspen spa room.
- In two identified residents' rooms; door guard / plastic covering of lower wall is loose and lifting creating sharp corners. Missing lower door plastic covering of two residents' rooms (under surface of brown glue is exposed);

- Damage to corner at door frame of the dining room exposing corner bead of lower and mid wall.

On October 05, 2016 the Environmental Services Supervisor (ESS) indicated to the inspector that maintenance staff become aware of areas in need of repair by accessing PM Works (electronic maintenance requisition software) several times a day for repair with anything resident related or high risk area will be fixed within 24 hours.

On October 05, 2016, inspector #570 interviewed the Administrator and the Extendicare Regional Director. The Administrator indicated the preventative maintenance program of the home is included in the PM Works for day to day maintenance schedule and also includes what was scheduled weekly or monthly for preventative maintenance. The Regional Director indicated that the focus was on repairing the deficiencies identified in the MOHLTC inspection report issued in January 2016 and the repairs to those deficiencies were completed. The Administrator further indicated that it is the expectation that all repairs were to be identified and completed; for that a maintenance supervisor was hired in August 2016 so that repairs can be done by maintenance staff if possible and to avoid bringing in contractors unless needed; it was taking too much time for contractors to finish needed repairs; also staff are encouraged to input all needed repairs using the PM works.

On October 05, 2016, during a tour of the Spa room in Pine unit and lounge area in Linden unit with the Regional Director, Administrator and Environmental Services Supervisor (ESS) all indicated that they were not aware of the Pine unit and Linden unit. The regional director indicated to the inspector that the spa room in Pine unit was recently repaired and the damage noted to walls was new. The ESS confirmed to the inspector that none of the damages noted in the Pine spa room and Linden TV lounge were reported to maintenance staff by using the PM Works software. The ESS further indicated that the expectation of the home is that staff will continue to use PM works to communicate needed repairs to the maintenance staff.

The compliance order was served on January 31, 2016 with a compliance date extended until July 31, 2016 required weekly audits and monthly analysis to be completed.
Review of the audits provided to inspector indicated that audits were not completed during the months of April and July 2016 and the audits provided were not completed

weekly as required by the compliance order and there were no audits completed for common areas. The resident room sanitation and room repair audits were completed on the following dates during the period of January 31, 2016 to July 31, 2016: Feb 22, 25, 26; March 8, 11, 17; May 16; June 15 and 21, 2016.

On October 06, 2016 interview with the Administrator and and the ESS both indicated to the inspector that issues identified requiring repair (damaged walls in SPA room in Pine unit) was not communicated to maintenance staff through the PM Works software; also not all issues identified by inspector were reported in PM works. The Administrator further indicated that she had no evidence that monthly analysis was completed as required by the order and that her expectation was that the former Environmental Services Manager (ESM) but was unable to provide any documentation.

The decision to re issue the compliance order was based on the widespread deficiencies related to the home, furnishings and equipment not being maintained in a safe condition and in a good state of repair identified during this inspection and the licensee's failure to comply with the requirements of the previous compliance order issued in January 2016 under inspection #2015_365194_0028. (570)

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

Apr 30, 2017(A1)

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

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

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

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

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 17 day of February 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SAMI JAROUR

Service Area Office /
Bureau régional de services : Ottawa