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

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 17, 18, ~~19~~, 24, 25, ~~26, Aug 22, 23, Sep 11, 13, 25, 26, 27~~, 2012	2012_072120_0055	Other

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

DOVER CLIFFS
501 St George Street, P.O. BOX 430, Port Dover, ON, N0A-1N0

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Environmental Services Supervisor, registered staff, non-registered staff and residents. (H-1371-12)

During the course of the inspection, the inspector(s) toured all levels of the home, measured lighting illumination levels, took water and air temperatures, reviewed air temperature and water temperature logs, reviewed service reports, tested door access control systems, tested window restrictors, observed the condition of furnishings, equipment and flooring, laundry & housekeeping services, reviewed infection control practices and reviewed environmental and infection prevention and control policies and procedures.

This review was conducted concurrently with the Resident Quality Inspection (2012-027192-0037).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Infection Prevention and Control

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

[O. Reg. 79/10, s. 15(1)(b)] The licensee of a long-term care home did not ensure that where bed rails are used,

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

The home contracted an external consultant to evaluate resident beds for entrapment risks in early February and again in May 2012. Approximately 26 beds were identified to have failed at least one zone, one being zone 2, which relates to the entrapment risk between the bottom of the bed rail and the top of the mattress. The home was informed that the mattresses needed to be replaced in order for the zone to pass and meet safety standards. On February 12, 2012, 12 new beds and mattresses were delivered to replace beds with the highest entrapment risk. However, no other immediate steps have been taken to mitigate the risk to the residents that remain on the 14 beds that did not pass the tests. During the tour of the resident rooms, numerous beds did not have mattress keepers in place (on the four corners to keep the mattress in place), a bed in an identified room had an overly long mattress on it and it could not fit between the mattress keepers, in another identified room, one bed was observed to be 1/4 off the bed frame and the resident was lying on the mattress and another bed in the same room had bed rails that do not comply with Health Canada's safety Guidelines for adult hospital beds. The administrator reported that the remaining beds will receive either a new mattress or bed system at the end of 2012 or in 2013.

Additional Required Actions:

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment where bed rails are used, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16.

Findings/Faits saillants :

The licensee of a long-term care home did not ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

Windows in the 1st & 2nd floor dining rooms, rooms #114, 202, 204, 206, 208, 215 and 217 were observed to be opened greater than 15 cm.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimeters, to be implemented voluntarily.

WN #3: 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.TABLEHomes to which the 2009 design manual appliesLocation - LuxEnclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 322.92 lux continuous consistent lighting throughoutIn all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 luxAll other homesLocation - LuxStairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 215.28 lux continuous consistent lighting throughoutIn all other areas of the home - Minimum levels of 215.84 luxEach drug cabinet - Minimum levels of 1,076.39 luxAt the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 luxO. Reg. 79/10, r. 18, Table.

Findings/Faits saillants :

The licensee of a long-term care home has not ensured that the lighting requirements set out in the Table to this section are maintained.

The 2nd floor tub room was measured with a light meter and observed to be zero lux above the toilet area and less than 40 lux under the two light fixtures over the tub area. The lux levels are required to be a minimum of 215.84.

The main corridor at the front of the home was measured to be 20 and 80 lux between light fixtures and 200 lux under several of the light fixtures. Lights were noted to be turned off in the main corridor on July 24, 2012 and when staff were asked why, they assumed that the fluorescent lights contributed to the heat in the building. All corridor lighting is required to be a consistent and continuous level of 215.28.

The 1st floor corridor on the north side has external light fixtures that are 7 feet apart. Directly under one light fixture, the lux level was 425. However, the lux level was not a continuous 215.28 as the meter moved along the corridor. The range of lux was 130 to 180 lux. Along the south corridor on the 1st floor, the lux level ranged between 50-125 lux between fixtures and 80 to 600 directly under various different light fixtures.

The basement corridor, which is accessible to residents, has ceiling light fixtures that are 10 feet apart just outside of the kitchen area the lux levels between fixtures was 0-25. Just outside of the activity room, the lights are 8 feet apart and the lux levels under the fixtures were well over 300 lux, however the lux levels in between fixtures was 75. The required minimum continuous and consistent level is 215.28.

Some resident washrooms (not all are configured the same) have areas that are below 215.84 lux. In room #214, the washroom was measured to be 150 lux over the sink and 50 lux over the toilet. The room lighting was 175 lux under the light fixture and almost 0 at the reading position from the over bed light.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that lighting requirements set out in the Table to this section are maintained, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following subsections:

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.
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. (1).

Findings/Faits saillants :

[O. Reg. 79/10, s.9(1)1.i. and iii.] The licensee of a long-term care home did not 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, and

iii. equipped with an audible door alarm that allows calls to be canceled only at the point of activation

The stairwell door leading from the 1st floor North to the basement, which is accessible to residents was not kept closed and locked and the alarm was not audible.

The door alarm did not sound and the magnetic locks did not connect on July 17 & 18, 2012. The magnets located on the door and door frame, which act as a locking mechanism, did not connect when the door was left to close by itself. The self closing device on the door to prevent the door from slamming, did not allow the door to close adequately. When a door was opened in the basement, the pressure in the stairwell caused the 1st floor door to close against the magnets. An audible alarm should have sounded approximately 30 seconds after the magnets did not lock, however no alarm sounded, even after 2 minutes. The alarm would notify staff that the doors are not adequately locked.

Numerous staff were observed to enter and exit this door and no one identified a problem.

Residents from the first floor have access to the basement to attend activities. They also have access to the North stairwell. This door is not equipped with an access control system. An alarm has been installed on the door which sounds when it is opened without using the key pad. On July 17th, the alarm was set to by pass. The alarm component is not considered to be an access control system.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors to stairways are kept closed and locked and that the alarms are audible, to be implemented voluntarily.

WN #5: 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 subsections:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. [O. Reg. 79/10, s. 229(2)(d)] The licensee has not ensured that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's infection prevention and control program, specifically the areas related to handling of soiled laundry and cleaning and disinfection of environmental surfaces, communal equipment and personal care articles, has not been evaluated to determine if it is in accordance with best practices. Currently, the Ontario Agency for Health Protection and Promotion has developed Best Practices for Environmental Cleaning for Prevention and Control of Infections, 2009 and Routine Practices and Additional Precautions in All Health Care Settings, 2011.

i) The home's practices and associated policies and procedures related to laundry processing and handling ESP A-15, dated September 2004 is not reflective of current best practices noted in the documents listed above. The policy directs staff to process "infected laundry" separately from other linen. This practice was determined to be in place in the home at the time of inspection based on conversations with laundry staff and by observing the red bags in various resident rooms.

According to both best practices documents, "routine laundering practices are adequate for laundering all linens, regardless of source; special handling of linen for residents on Additional Precautions is not required". No distinctions are made between laundry from those who are ill from those who are not ill. Making such distinctions causes complacency when handling soiled linen in general and the heavy reliance on someone to identify a resident with a contagious organism. The home has clearly made a distinction in their policies and procedures and has not made changes to their policies or practices reflective of current best practices.

ii) Both soiled utility rooms were observed to have a sign posted on a cabinet that directed staff to "rinse laundry before sending to laundry" by using the hopper. The Director of Care reported that she initiated the procedure so that laundry staff would not be responsible for removing material from the linens. No other alternatives have been considered. Best practices recommend the minimization of fecal aerosolization to prevent the contamination of surrounding surfaces and materials. The home's policy A-10 states that "soiled linen should be handled with minimum of agitation to prevent contamination of the air". The direction to rinse the soiled linen is contradictory to both the home's policy and best practice documents.

The environmental services supervisor (ESS) and the Director of Care were unaware that the policies and procedures did not meet current best practices and the ESS was unaware that best practices documents were available for laundry processing.

2. [O. Reg. 79/10, s. 229(4)] The licensee has not ensured that all staff participate in the implementation of the program.

The program, relating to infection prevention and control is not being implemented because staff are not participating and following the home's established policies and procedures for cleaning and disinfection of various personal care items and the appropriate storage of these items.

i) Policy LTC-1-305,dated December 2008 titled "Equipment Cleaning, Disinfection, Sterilization" is not being followed. Numerous wash basinsin identified rooms were observed stored on shelves in resident washrooms with left over soapy water from morning care or had some scale build-up in them. Directions require staff to take the article to the soiled utility room where they are to be cleaned and disinfected using Virox, daily after each use. However the directive does not indicate what form of Virox to use, liquid or wet wipe. No liquid Virox was identified in the 2nd floor utility room on July 17 or 24, 2012.

The wash basins in two identified resident washrooms had visible matter on the exterior surfaces over a 4-day period. A bed pan was observed to be soiled and stored on a toilet tank in an identified resident washroom on July 17, 2012. On July 24, 2012, a bed pan was found on the floor beside the toilet, visibly soiled. On July 17, 2012, a urinal was left on the floor in a resident washroom. A bed pan and urinal were left on the toilet tank in a resident's washroom on July 17, 2012 and then the bed pan was found on floor next to toilet on July 24, 2012. A stained bed pan was found under the sink in an identified resident washroom. These observations conclude that staff are not storing the items properly and not taking soiled items to the soiled utility room to be cleaned and disinfected after each use as per the home's policy and best

practices. Some confusion exists with written staff directives. The night duties routine for personal support workers direct staff to collect all wash basins from resident rooms on Wednesdays for cleaning and disinfection and other directives require cleaning and disinfection after each use.

ii) Soiled utility rooms both contained unclean articles stored on shelves above the counter over a 4-day period. Staff are not ensuring that the articles such as bed pans, urinals, urine measures and wash basins are cleaned and disinfected and returned to residents as per policy LTC-1-305. The first floor utility room had 2 visually stained urinals, one bed pan with visible debris and one urine measure with visible matter on the exterior surface. The second floor soiled utility room had 3 green soiled bedpans and 2 stained urinals on the shelves on July 24 & 25, 2012. The shelving area is where cleaned articles are stored, according to staff. Best practices suggests that all cleaned and disinfected articles be stored in an alternative location, away from sources of contamination.

iii) Both soiled utility rooms were observed to have wall mounted dispensers of a non-hospital grade product called "D10" which is a sanitizer with label directions to use only on food contact surfaces and dishware/flatware. Nursing staff reported filling their spray bottles with the product in the past and some continue to do so as 2 spray bottles of "D10" were found in the 1st floor tub room on two separate days. A sign was posted next to the dispensing unit in the 2nd floor soiled utility room directing staff to "add 3 pumps of D10 to a full sink of water" and soak the "utensils" for 10 minutes. No definition was given for "utensils" but it was assumed by staff that the utensils are bedpans, urinals and washbasins. The sign also directed staff to use R2A (which is a hospital grade disinfectant) on commode chairs. No R2A or other hospital grade liquid disinfectant could be located in the 2nd floor utility room. Hospital grade disinfectant wet wipes were however present in the 2nd floor soiled utility room and Virox 5 RTU in the 1st floor soiled utility room. According the Director of Care, the Virox 5 RTU is the product staff are to use instead of the D10 sanitizer. This direction was not posted in the rooms for staff and policy LTC-I-350 requires staff to use one approved disinfectant and names "Virox" as one of the options but does not mention the use of Virox wet wipes. None of the policies refers to these wipes and how staff are to use them and on what surfaces.

iv) Unlabeled hairbrushes, toothbrushes, basins and combs noted in identified shared resident washrooms. The home's night duties for personal support workers requires staff to label all personal products on Mondays and that all personal items are checked for labels in each washroom on Fridays.

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 ensured that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and that staff participate in the implementation of the program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

The licensee of a long-term care home has not ensured that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Slings used with mechanical lifts were observed to be well past the manufacturer's expected operational life for fabric slings. The manufacturer's guidelines state that life expectancy for slings is approximately 2 years from the date of manufacture and only if the slings have been cleaned, maintained and disinfected in accordance with documents from the company such as their "Operating and Product Care Instructions" and the "Preventive Maintenance Schedule".

Slings were observed hanging in resident rooms, from lifts and in tub/shower rooms. Many of the slings were observed to have tags on them that were completely faded and unreadable. The manufacturer warns that a sling not be used when a tag is unreadable (Patient Care Sling Selection and Usage Toolkit). Other slings had bare visible markings on them with dates of 2004 & 2005 and some were clearly labeled with a date of 2011. The manufacturers' guidelines state that laundering contributes to wear and tear of the slings, compromising safety over time.

The Director of Care reported that she visually inspected all of the slings but only documented when 3 new slings were placed into circulation. The manufacturer suggests that all sling inspections be documented and that the date of inspection, identifying sling code and whether it passed or failed an inspection be recorded. According to the home's policy LTC-P-70, the date the sling is put into circulation needs to be recorded. Only 3 slings have been placed into circulation within the last few months and these have been recorded. Slings placed into circulation prior to that have not been recorded and no documentation of their inspections has been kept.

A "Hamock 6" sling, with a mesh design on the 2nd floor was observed hanging on a lift. It did not have a readable label and therefore the date of manufacture could not be determined. The sling had stitching missing around a portion of the trim. Another sling with worn tags, located in the first floor tub/shower room had worn and frayed straps where it attached to the fabric. Staff are not examining the slings before each use and removing any defective slings from circulation as required by the home's policy LTC-P-70 and the manufacturer's instructions.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following subsections:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

[O. Reg. 79/10, 90(1)(b)] The licensee has not ensured that there are schedules and procedures in place for routine, preventive and remedial maintenance.

Although the home has policies, procedures and schedules in place for certain preventive and routine equipment checks in the home, the program is mostly remedial with respect to walls, floors, lighting, windows, beds, shelving, resident furnishings, plumbing fixtures such as toilets and sinks and nurse call system.

* Shelving made of particle board, located in each resident bedroom and washroom has become rough and difficult to clean. The shelves have been painted and repainted however the particles from the wood stick out and have become water damaged in some cases. Many of the shelves had exposed raw wood surfaces.

* Dining room table bases located in the 2nd floor dining room have become rusty and others that have been painted were noted to be peeling. The management of the home reported that the furniture in this dining room is slated for replacement in 2012.

* Tub rooms on both 1st and 2nd floors have damaged corners and walls. Patching and repainting is evident however the program has not been effective. Damage continues to occur when staff use equipment in the room.

* The flooring material in room #202 noted to have duct tape over seams and two holes noted, the flooring material in the 2nd floor tub room is ripped in one area, the raised flooring material that makes up the baseboard has split on wall corners in the 1st floor tub room and the seam has split in the flooring material on the 1st floor near the fire exit doors on the North wing. Duct tape noted on the floor covering a split seam near #105. The management of the home reported that the flooring material along this corridor is scheduled for replacement in 2012.

* The surface of the tub lift chair in the 2nd floor tub room is peeling off and the surface is irregular and no longer easy to clean.

* The exhaust fan in room #202 and #105 were not functional.

* The roof top air conditioning unit located on the south side of the building failed in September 2011 and has not been repaired as of the date of this inspection. The unit supplied air conditioned air to both the first and second floors of the home on the south side of the building. As a result of the disrepair, the home was not able to provide cooled or conditioned air to all of their residents for comfort during heat alerts. Instead, small portable air conditioning units, supplied by either the family or by the home, were installed in various resident rooms and dining rooms. During the inspection, it was noted that the larger common areas such as the dining rooms, which can accommodate all residents, could not be sufficiently cooled by the portable units. The units were also subject to frequent power lapses due to the buildings insufficient electrical capacity to operate the air conditioning units, oxygen machines, air mattresses, fans and electrical beds.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following subsections:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

The licensee has not ensured that immediate action is taken to deal with pests.

Numerous house flies were noted throughout the home during the inspection. Various residents had fly swatters in their rooms. Hundreds of dead insects were noted in the home around window sills, on the heaters, in light covers indicating that flying insects have access into the home. No action had been taken by the home to reduce the access of insects into the home. The home's pest control contract includes fly control, however the method to control the flies is limited to sticky traps and ultra violet light stations in very few locations which do not seem to impact the fly population in the home.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

[O. Reg. 79/10, s.87(2)(a)] The licensee has not ensured that procedures are developed and implemented for:

(a) cleaning of the home, including, (i) resident bedrooms, floors, furnishings, contact surfaces, and (ii)common areas and staff areas

*Resident bedrooms were observed to have many dead flying insects on the heater surfaces and window sills over a 4-day period. The home's job routines for housekeepers dated November 2010 (posted in the housekeeping rooms) state that window sills are to be dusted daily, however there is no mention of how often or if heaters need to be cleaned.

*Resident toilet surface and call bell pull in in an identified resident washroom noted to be visibly soiled on July 16, 17 and July 24, 2012.

*Floor surfaces were observed to be soiled, with visible loose debris between July 16 & 18th, 2012 in front of the elevator on the first floor and on the 2nd floor behind furnishings near the elevator. Resident bedroom floors were noted to be very dusty the week of July 16th. Discussion with the environmental manager revealed that a housekeeper could not fulfill her duties on a particular day and her shift could not be covered. The cleaning of the floors was not conducted during this time and cleaning routines were affected on both floors as only one housekeeper was available for the entire building.

*Exhaust vent covers were observed to be very dusty in various resident washrooms and in soiled utility rooms during the entire inspection period. The home's job routines for housekeepers dated November 2010 (posted in the housekeeping rooms) state that vents are to be dusted daily.

*Portable fans located in the serveries noted to be dusty, blowing over top of cleaned and uncovered dishes throughout the week of July 17, 2012. Debris noted on the top dishes on July 17, 2012.

*Microwave located in 2nd floor dining room noted to be soiled on the interior on July 17, 2012. Policy D-05-205 requires that staff wipe the surfaces immediately after use.

*Dead insects were observed inside of light covers in corridors on all three floors. The maintenance person reported that the light covers are cleaned once per year. The home's policy C-125 requires lights to be cleaned bi-annually or as required.

*Mould growth observed on the air conditioning unit directional fins in rooms #219, 214 and 115. No policy or procedure has been developed for the care and maintenance of these units.

*The handles to all of the servery cabinets were observed to be soiled over a 4 day period. A deep cleaning schedule posted in the main kitchen requires staff to clean serveries every Thursday, however the schedule does not address cabinet surfaces.

2. [O. Reg. 79/10, s.87(2)(d)] As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee has not ensured that procedures are developed and implemented for,

(d) addressing incidents of lingering offensive odours.

Urine odours were strong in an identified resident washroom on both July 17 & 24th, 2012, throughout the day. The room had been cleaned, however urine odour persisted. An urine catheter bag was observed to be hanging off a towel bar on both days, however the odour did not appear to be originating from the bag.

Issued on this 27th day of September, 2012

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

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) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2012_072120_0055
Type of Inspection / Genre d'inspection:	Other
Date of Inspection / Date de l'inspection :	Jul 17, 18, ~~19~~, 24, 25, ~~26, Aug 22, 23, Sep 11, 13, 25, 26, 27~~, 2012 BJ
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	DOVER CLIFFS 501 St George Street, P.O. BOX 430, Port Dover, ON, N0A-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PAULINE LYNE

To REVERA LONG TERM CARE INC., 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

1) Institute immediately appropriate measures (in accordance with Health Canada's Guidance Document entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and other Hazards") to reduce or mitigate potential risks to residents who currently sleep on a bed system that did not pass all 7 zones of entrapment (based on the latest bed safety audit).
2) Develop an interdisciplinary clinical risk assessment tool which takes into consideration resident's medical needs, comfort, and freedom of movement for a safe bed environment. The tool is to be used to determine what type of bed system is appropriate for the resident.
3) Each resident's plan of care shall identify the bed safety interventions that are appropriate for them, as well as those interventions that are not effective, if they were previously attempted and determined not to be appropriate for the resident.

The above actions shall be complied with by October 31, 2012.

Grounds / Motifs :

1. [O. Reg. 79/10, s. 15(1)(b)] The licensee of a long-term care home did not ensure that where bed rails are used,

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

The home contracted an external consultant to evaluate resident beds for entrapment risks in early February and again in May 2012. Approximately 26 beds were identified to have failed at least one zone, one being zone 2, which relates to the entrapment risk between the bottom of the bed rail and the top of the mattress. The home was informed that the mattresses needed to be replaced in order for the zone to pass and meet safety standards. On February 12, 2012, 12 new beds and mattresses were delivered to replace beds with the highest entrapment risk. However, no other immediate steps have been taken to mitigate the risk to the residents that remain on the 14 beds that did not pass the tests. During the tour of the resident rooms, numerous beds did not have mattress keepers in place (on the four corners to keep the mattress in place), a bed in an identified room had an overly long mattress on it and it could not fit between the mattress keepers, in another identified room, one bed was observed to be 1/4 off the bed frame and the resident was lying on the mattress and another bed in the same room had bed rails that do not comply with Health Canada's safety Guidelines for adult hospital beds. The administrator reported that the remaining beds will receive either a new mattress or bed system at the end of 2012 or in 2013. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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 27th day of September, 2012

Signature of Inspector / Signature de l'inspecteur : B. Susnik

Name of Inspector / Nom de l'inspecteur : BERNADETTE SUSNIK

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