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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jan 05, 2017;	2016_290551_0030 (A1)	034916-16	Follow up

Licensee/Titulaire de permis

DUNDAS MANOR LIMITED
533 CLARENCE STREET P.O. BOX 970 WINCHESTER ON K0C 2K0

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

DUNDAS MANOR NURSING HOME
533 CLARENCE STREET P.O. BOX 970 WINCHESTER ON K0C 2K0

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

MEGAN MACPHAIL (551) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Change to the wording in paragraph #7 of the finding/grounds.

Ontario

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Ministère de la Santé et des Soins de longue durée

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Issued on this 5 day of January 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

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Ministère de la Santé et des Soins de longue durée

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

MEGAN MACPHAIL (551) - (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): December 28, 2016.

Log 034916-16 (follow up to a compliance order) was inspected.

During the course of the inspection, the inspector(s) spoke with residents, a family member, the Director of Care, the Director of Building Maintenance and the Administrator.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that the home is a safe and secure environment for its residents by not conducting an assessment of each individual resident to determine the appropriate placement of the bed in relation to the baseboard heater, based on the assessed needs of the resident, as was ordered in compliance order (CO) #001.

The licensee was issued CO #001 on December 16, 2016 with a compliance due date of December 27, 2016. The licensee was ordered to: eliminate the safety hazards associated with the use of baseboard heaters by:
2. Conducting a record of an assessment of each individual resident to determine the appropriate placement of the bed in relation to the baseboard heater, based on the identified needs of the resident.

On December 28, 2016, the Director of Building Maintenance (DBM) told Inspector #551 that the appropriate placement of all residents' beds in relation to the baseboard heater was determined to be two feet or twenty four inches. The DBM stated that the distance was measured from the edge of the mattress to the wall, on which sits a baseboard heater. The DBM, the Administrator and the Director of Care (DOC) stated that this distance of two feet was applied to all 98 beds in the home, with the exception of four residents who refused.

The Administrator and DOC stated that no assessment of each individual resident, based on the identified needs of the resident, had been conducted as two feet had been determined to be a relatively safe distance from the bed to the baseboard heater, and was applied to all of the beds in the home. The Administrator and DOC stated that once the four residents refused to move their beds the recommended distance, no further assessment was conducted on these residents, and that the residents or their SDM had signed a waiver.

Resident #001, #002, #003 and #004, who reside in private rooms, declined to have their beds placed two feet away from the baseboard heater. Resident #001 and #002 have the head of their beds positioned perpendicular to the base board heaters, and resident #003 and #004 have their beds positioned parallel to the base board heaters. According to the DBM, resident #003 and #004's beds are fifteen to eighteen inches away from the base board heaters.

The DBM provided to the inspector a list with 46 beds and a measurement of the distance from the edge of the mattress to the wall. The beds of resident #001, #002, #003 and #004, who refused to have their beds moved, and 48 other residents who reside in ward type rooms and whose beds are not in proximity to the baseboard heaters, are not on this list.

According to the home's policy titled "Bed Placement in relation to Baseboard Heaters", the bed placement shall be measured as twenty four inches from the edge of the mattress to the wall.

The residents who did not want their beds moved signed a form indicating what the recommendation was, that "the risks have been fully explained to you" and that the resident/SDM had chosen not to comply with the policy.

The form does not indicate what the risks are, or that they are based on the identified needs of the individual resident. The Administrator stated that in the case of resident #002, the bed was not moved as it would interfere with the lift. The Administrator was not able to provide any documentation to support that the individual needs of the resident had been assessed with regards to bed placement in relation to base board heaters for resident #001, #002, #003 and #004. [s. 5.]

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

Issued on this 5 day of January 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) : MEGAN MACPHAIL (551) - (A1)

Inspection No. / No de l'inspection : 2016_290551_0030 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 034916-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Jan 05, 2017;(A1)

Licensee / Titulaire de permis :
DUNDAS MANOR LIMITED
533 CLARENCE STREET, P.O. BOX 970,
WINCHESTER, ON, K0C-2K0

LTC Home / Foyer de SLD :
DUNDAS MANOR NURSING HOME
533 CLARENCE STREET, P.O. BOX 970,
WINCHESTER, ON, K0C-2K0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Norm Slatter

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

To DUNDAS MANOR LIMITED, 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: 2016_287548_0029, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee is hereby ordered to eliminate the safety hazards associated with the use of base board heaters by:
conducting an assessment of resident #001, #002, #003 and #004, and based on the identified needs of the resident, determining the appropriate placement of the bed in relation to the base board heater. This assessment is to be documented.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that the home is a safe and secure environment for its residents by not conducting an assessment of each individual resident to determine the appropriate placement of the bed in relation to the baseboard heater, based on the assessed needs of the resident, as was ordered in compliance order (CO) #001.

The licensee was issued CO #001 on December 16, 2016 with a compliance due date of December 27, 2016. The licensee was ordered to: eliminate the safety hazards associated with the use of baseboard heaters by:
2. Conducting a record of an assessment of each individual resident to determine the appropriate placement of the bed in relation to the baseboard heater, based on the identified needs of the resident.

On December 28, 2016, the Director of Building Maintenance (DBM) told Inspector #551 that the appropriate placement of all residents' beds in relation to the baseboard heater was determined to be two feet or twenty four inches. The DBM stated that the distance was measured from the edge of the mattress to the wall, on which sits a baseboard heater. The DBM, the Administrator and the Director of Care (DOC) stated that this distance of two feet was applied to all 98 beds in the home, with the exception of four residents who refused.

The Administrator and DOC stated that no assessment of each individual resident, based on the identified needs of the resident, had been conducted as two feet had been determined to be a relatively safe distance from the bed to the baseboard heater, and was applied to all of the beds in the home. The Administrator and DOC stated that once the four residents refused to move their beds the recommended distance, no further assessment was conducted on these residents, and that the residents or their SDM had signed a waiver.

Resident #001, #002, #003 and #004, who reside in private rooms, declined to have their beds placed two feet away from the baseboard heater. Resident #001 and #002 have the head of their beds positioned perpendicular to the base board heaters, and resident #003 and #004 have their beds positioned parallel to the base board heaters. According to the DBM, resident #003 and #004's beds are fifteen to eighteen inches away from the base board heaters.

The DBM provided to the inspector a list with 46 beds and a measurement of the distance from the edge of the mattress to the wall. The beds of resident #001, #002, #003 and #004, who refused to have their beds moved, and 48 other residents who reside in ward type rooms and whose beds are not in proximity to the baseboard heaters, are not on this list.

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The form does not indicate what the risks are, or that they are based on the identified needs of the individual resident. The Administrator stated that in the case of resident #002, the bed was not moved as it would interfere with the lift. The Administrator was not able to provide any documentation to support that the individual needs of the resident had been assessed with regards to bed placement in relation to base board heaters for resident #001, #002, #003 and #004. (551)

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

Jan 16, 2017

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

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 5 day of January 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MEGAN MACPHAIL

Service Area Office /
Bureau régional de services : Ottawa