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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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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 22, 2016;	2015_336620_0008 (A1)	029533-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE TIMMINS
62 St-Jean Avenue TIMMINS ON P4R 0A6

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

ALAIN PLANTE (620) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has been provided an extension to February 29, 2016, due to concerns with manufacturers.

Issued on this 22 day of January 2016 (A1)

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

Original report signed by the inspector.

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

ALAIN PLANTE (620) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): November 02 to 13, 2015.

During the course of the inspection, the inspector (s) reviewed residents' health care records, reviewed various policies, procedures, and programs, and conducted an initial tour and daily walk-through of the home. The inspector (s) also observed the delivery of resident care, dining service, staff to resident interactions, medication administration, and application of the Infection Prevention and Control Program.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Support Services Manager, Program Manager, RAI/MDS Manager, Office Manager, Care Coordinator, a Physician, Behavioural Support Lead (BSO), a Pharmacist, Residents' Council Chair, Assistant to Family Council/Social Worker, Food Services Manager, Registered Nurses (RN), a Registered Dietitian (RD), Registered Practical Nurses (RPN), a Maintenance staff member, Personal Support Workers (PSW), Residents, and Residents' Substitute Decision Makers (SDM).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

15 WN(s)
8 VPC(s)
3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in different aspects of care collaborated with each other in the assessment of resident #010 so that their assessments were integrated, consistent with, and complemented each other.

Inspector #625 reviewed the Weekly Wound Assessments, an Annual Medical Assessment, and a Head to Toe Skin Assessment for resident #010. The documents revealed that resident #010 had a wound. Resident #010's Weekly Wound Assessments, Annual Medical Assessments, and Head to Toe Skin Assessments revealed that during a 60 day span the wound was documented inconsistently. On one occasion the wound was documented as non-existent. Three times the wound was documented in conflicting locations and on three occasions the wound was documented inconsistently with regard to stage of wound.

Staff member #125 was interviewed by Inspector #625 and stated that resident #010 currently had a wound. The staff member further stated that no Physician's order was in place for the treatment of the wound.

Inspector #625 interviewed Staff member #110 who stated that they had last assessed the resident 59 days earlier, due to the presence of a wound. They stated that they were required to check an electronic spreadsheet to see if the resident's wound had deteriorated. They also stated they had not checked the spreadsheet for a 62 day period, and should have. Staff member #110 was not aware of the change in the severity of resident #010's wound and should have been.

Inspector #625 interviewed Staff member #123 regarding resident #010's wound.

They referred to an electronic wound tracking spreadsheet that indicated the wound originated 65 days earlier. They noted that the Weekly Wound Assessments listed conflicting information for the location and stage of the wound. The Staff member confirmed that the wound was improperly documented in terms of location on numerous occasions. They were unaware that staff were cleansing the wound with normal saline and applying a dressing as observed by Inspector #625. They stated that if resident #010 had a wound treatment being performed it should have been entered into the care plan indicating to refer to the resident's Treatment Administration Record (TAR), where the specific dressing instructions should be listed. They confirmed that there were no instructions in the care plan or the TAR, and should have been.

Inspector #625 interviewed Administrator #111 who stated that staff members were expected to engage a multidisciplinary team to manage wounds. The Administrator was uncertain as to why the interdisciplinary staff were not aware that resident #010's wound had deteriorated. They confirmed that some members of the interdisciplinary staff had not received a referral since the initial referral, and should have.

The assessments and documentation for resident #010's wound was inconsistent with respect to the location of the wound, the stage of the wound and the presence of the wound. Staff and others involved in different aspects of the resident's care had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During the lunch meal service, staff member #107 asked the dietary aide if the entree provided for resident #048 was of an alternate diet type. The dietary aide reviewed the resident diet list and responded that resident #048 was to receive a regular diet.

A review of the physician orders revealed that resident #048 was supposed to have an alternate diet. An order from the staff member #136 advised to change the diet texture to regular. A review of the Resident Diet List indicated resident #048 was to receive a regular diet and regular texture.

Interview with staff member #136 revealed an error had occurred when the change in the diet texture was communicated to the dietary department. The transcription error

involved the resident diet being changed to a regular diet and regular texture consistency rather than being recorded an alternate diet type with a regular texture.

Staff member #136 confirmed resident #048 had not received the correct diet during the lunch meal service, and should have. [s. 6. (7)]

3. The licensee failed to ensure that care was provided to the resident as specified in the plan of care. Specifically, the licensee failed to ensure that wound care was provided to resident #003 as specified in the resident TAR as ordered by the resident's physician.

The most recent Weekly Wound Assessment for resident #003 indicated that resident #003 had a wound.

Inspector #625 reviewed resident #003's Medication Review Report that listed the order for the dressing which provided direction on how the staff were to care for the wound.

Inspector #625 observed staff member #125 complete the dressing change for resident #003. The staff member did not follow the directions as listed in the order.

Inspector #625 interviewed staff member #125 following the dressing change. The staff member identified that they had not done the dressing change as it was ordered.

Inspector #625 interviewed staff member #123. They confirmed that the dressing change did not occur as ordered. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one RN who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

A record review by Inspector #620 of the RN coverage for a three month period revealed that on the following dates there was no RN on duty within the home during the Night shift (2300-0700 hours): September 23, 2015, September 24, 2015, October 08, 2015, October 14, 2015, and October 18, 2015.

A review of the home's documented process for replacing RNs revealed that if an RN was absent, a part-time or casual RN would be called in. If the call in of the part-time or casual RN was unsuccessful, a full-time RN would be called in. If no RN was available, the position would then be filled by a RPN.

Manager #148 (Manager responsible for staff scheduling) was interviewed by Inspector # 620. The Manager stated that the home replaces an absent RN with RNs if possible but if that was not possible, they replace with an RPN. They indicated that they often struggle to replace RNs if their full time RN staff are absent. The Office Manager stated that they were aware of the requirement to maintain 24 hour RN coverage, and that this had not always occurred.

Inspector # 620 interviewed Administrator #111. The Administrator stated that they were aware that on occasion the home replaces a RN with a RPN if the home was unable to call in a staff RN. The Administrator was aware that the home's written staffing process involved replacing a RN with a RPN. They stated that there was currently no effort to recruit additional RN staff. The Administrator confirmed that they were aware of the requirement to provide 24 hour RN staffing and that this did not always occur, and should have. [s. 8. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Inspector #621 identified maintenance related concerns in numerous areas of the home. In the Porcupine and Big Water Lake Unit there was an abundance of unpainted patch work on the walls. The Big Water Lake Unit also had panels missing on radiators in the lounge and bathrooms. The Mattagami River Unit had one panel of a radiator that was removed and lying on the floor next to the toilet. The Gillies Lake Unit had a large segment of tile missing on the wall and base board was found broken and taped back together.

Further Observation by Inspector # 620 revealed that nine of 11 parking lot lights were not working. Inspector # 620 also identified that the floor covering in a tub room had a seam that was separated, delaminated from the substrate, and contained a two inch depression below the floor covering that was holding water.

Inspector # 620 interviewed staff member #114. They revealed that they were aware that the lighting on the exterior of the home was not currently functional and that it had been in this condition since the early summer of 2015. They confirmed that the wall covering and radiator covers were in disrepair throughout the home. Staff member #114 indicated that the home was having difficulty addressing the maintenance of wall surfaces.

Inspector # 620 interviewed the Administrator. They stated that they were aware that the flooring in a tub room had separated, and was holding water. The Administrator also revealed that they were, "losing ground" in the effort to maintain wall surfaces and radiator covers. The Administrator stated that they did not have enough staff to address the remedial maintenance concerns the home was required to undertake. [s. 15. (2) (c)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to fully respect and promote the resident's right to be properly sheltered, fed, clothed, groomed, and cared for in a manner consistent with his/her needs; specifically, resident #010's preferences regarding grooming.

On a specified date resident #010 received grooming contrary to their preference. This

was undertaken without the knowledge, awareness, and consent of their SDM and family member #135.

Resident #010's SDM sent an email to the staff member #133. The email stated that one of the home's staff provided grooming contrary to resident #010's preferences and had not consulted the family prior to this happening. The family member asked the staff member to forward the email to the appropriate person. The SDM further expressed their concern about the unauthorized grooming during resident #010's care conference.

Inspector #625 interviewed resident #010's family member who stated that resident #010 received undesirable grooming, without the knowledge or consent of the resident's SDM. The family member said that resident #010 would not have wanted this type of grooming; it was drastic and offensive to their person. The SDM had sent an email to the home outlining their concern but did not receive a response.

Inspector #625 interviewed the SDM who confirmed that no consultation had occurred with the family prior to the resident's grooming. The SDM stated they had sent an email to staff member #133 and also brought up the issue during the resident's care conference. The SDM stated that no response was received to the email or to the issue they raised in the care conference.

Inspector #625 interviewed the Administrator who had not previously been aware of the concern. The Administrator also stated that staff member #133 no longer worked in the home but that the Administrator would follow-up with the family and conduct an investigation into what had occurred. [s. 3. (1)4.]

2. The licensee failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Inspector #621 and #153 conducted a tour of the home and observed an active Point Click Care Monitor in the Porcupine Lake Unit opened to residents' names and room numbers for six to eight residents. An active Point of Care Monitor, on the Big Water Lake Unit, was also observed to be opened to information for resident #018. Inspector #620 and #625 observed a medication cart on Mattagami River Unit with the screen viewable, unlocked, and logged in to Point Click Care on a specific resident's medication administration record (MAR). Inspector # 620 further discovered another unlocked medication cart on the Mattagami River Unit with an active screen open to a

resident's Personal Health Information. Resident #017 was in front of the medication cart in full view of another resident's Personal Health Information.

Staff member #130 began medication administration to resident #025 by asking Inspectors #620 and #625 if they were required to lock the computer monitor every time they left the medication cart to administer medications to residents in their bedrooms, thereby leaving the cart in the hallway. Staff member #130 further stated that the current practice was to lock the monitor only when leaving the cart in the dining room.

Inspectors #620 and #625 met with DOC #112. The DOC stated that it was the home's expectation that the computer monitor should be locked to protect Personal Health Information when staff are not present. The DOC agreed that the residents' Personal Health Information had not been appropriately safeguarded, as required by the Act, and should have been. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the rights of residents are fully respected and promoted specifically that Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, and that resident PHI is kept in accordance with PHIPA 2004., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily used by residents, staff and visitors at all times.

Inspector #620 identified that the call bell in a bathroom of a room on Mattagami River Unit was wrapped around the grab bar which hindered the call bell from being activated. Additionally, the light indicating when the call bell had been activated was not functioning at the 'Marquis' main panel. Inspector #620 further identified that the call bell in a bathroom of a room on the Gillies Lake Unit was wrapped around the safety rail which hindered the call bell from being activated. A third non-functioning call bell was identified by Inspector # 620 on the Kamiskotia Lake Unit. The call bell in the bathroom was not operative. When activation was attempted, the call bell did not illuminate in hall or at panel on the wall in bathroom.

Inspector # 628 identified that the call bell in a bathroom on the Gillies Lake Unit was wrapped around the safety rail which hindered the call bell from being activated. Staff member #101 confirmed that the call bell was not working and should have been. When asked about the process for having the call system repaired, the staff member confirmed that when a call bell was not functional the staff call Staff Member #113 to have it fixed.

Staff member #130 stated to Inspector #620 that if the call bell system was inoperative, they would call Maintenance staff member #113. The staff member stated that PSW staff may check functionality periodically but they were not aware of a formal process for monitoring the call bell system.

Maintenance staff member #113 was interviewed about the home's Resident-Staff Communication Response System. They stated that each resident bedroom and bathroom had a call bell and that the call bell cords were to hang freely; call bells were not to be wrapped around grab bars. They further explained that it was the home's expectation that staff document non-functional call bells or maintenance issues in the Maintenance Book which was located on each resident care unit. Maintenance staff member #113 stated that they conduct daily rounds to check the maintenance book to identify and address concerns.

Inspector #620 and #113 reviewed the Maintenance Books located on the Kamiskotia Lake, Gillies Lake, and Porcupine Lake Unit; noting, there was no documentation reporting concerns related to non-functioning call bells.

Interviews with the Administrator and staff member #114 confirmed that it was the home's expectation that inoperable call bells would be recorded in the Unit Maintenance Book for repair. The Administrator confirmed that in rooms on the Mattagami River Unit, the Gillies Lake Unit, and the Porcupine Lake Unit the call bells were made inoperable by being wrapped around the bathroom grab bar; the Administrator stated this should not have occurred. The Administrator acknowledged that the call bell in a room on the Kamiskotia Unit was not functioning as required, and should have been. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home is equipped with a resident-staff communication and response system that can be easily used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents' heights were measured and recorded annually as specified in the Home's Nutrition Care and Hydration Program.

Upon review of the following resident health records it was found that an annual height measure was not recorded for:

resident #006, last height taken February 26, 2013;

resident #003, last height taken November 23, 2013;

resident #005, last height taken November 25, 2010;

resident #007, last height taken April 10, 2010;

resident #010 last height taken October 24, 2012;

resident #015 last height taken December 17, 2013.

A review of the Home's policy titled, "Weight Change Program # RESI-05-02-07" revised in November 2013, identified that care staff were to take heights on admission and at least annually thereafter. Recording of weights were to be documented on the facility specific height worksheet.

An interview with the DOC #112 confirmed the Home's expectation for measuring heights annually. The DOC confirmed that this was the legislative requirement, and that the home was not completing annual heights, and should have been. [s. 68. (2) (e) (ii)]

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 ensuring that the Home's Nutrition Care and Hydration Program is complied with, specifically regarding the measuring and recording of each resident's height annually, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with a change of 5 per cent of body weight, or more, over one month were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

The monthly weight measure of resident #001 was recorded in the electronic health record. This measurement represented a significant weight loss of 7.2 per cent.

An interview with the staff member #110 identified the process for monitoring weights. The weight monitoring involved the staff on the home units measuring monthly weights and inputting the data into the electronic health record. Weights are to be done monthly. If more than a 2.5 kilogram difference was identified, then staff was to reweigh as per the Home's Weight Change Program Policy # RESI-05-02-07 and document the revised weight.

The RD was asked how they were made aware of nutrition issues in the home. The RD stated that the staff reported in person, through voicemail, office phone calls, or the paper referral process. Based on the referral, RD #110 indicated that a further review of the weight variance reports would be completed; a manual review of the monthly weights was also indicated as a way to confirm weight variances to verify electronic data. RD #110 confirmed that resident #001 had a weight loss over the past month. The RD acknowledged that a referral had not yet been received as per the policy entitled, "Registered Dietitian/Dietary Department Communication and Referral."

An interview with the DOC and the staff member #120 confirmed that resident #001 had a significant weight change as evidenced by the Weights and Vitals Report. Based on the results of the report, there should have been action taken to include a reweigh and referral to the RD. The DOC and staff member #120 confirmed neither a referral to the RD, nor a reweigh occurred, and should have. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 ensuring that residents with a change of 5 per cent of body weight, or more, over one month are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance.
A review of the home's Maintenance Program revealed that there were no documented processes, schedules or procedures in place to attend to the remedial maintenance of identified wall surfaces, radiators and lighting.

Inspector #620 interviewed staff member #114. They were asked to describe the services and procedures related to remedial maintenance within the interior and exterior of the home. They noted that there was no formal process, schedule or procedure to attend to remedial maintenance. The staff member did note that there was a biannual inspection schedule for preventative maintenance; however, there was no formal documented process to track the completion of specific remedial maintenance tasks. They further confirmed that the home had difficulty addressing the home's maintenance concerns.

Inspector # 620 interviewed the Administrator. The Administrator acknowledged awareness of the maintenance concerns and stated that they are "losing ground" in the effort to maintain wall surfaces and radiator covers. They further stated that they did not have the staff, schedules, and procedures in place to address the remedial maintenance concerns within the home, and should have. [s. 90. (1) (b)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

Inspectors #627, #621 and #153 identified the unsafe storage of prescription topical medications on the first floor of the home which included two tub rooms located on Mattagami River Unit, and resident home areas of the Pearl Lake Unit. The Gillies Lake Unit also had a basket of prescription topical medications sitting on a cart in the clean utility room with door found unlocked and ajar.

Inspector # 628 conducted interviews with staff member #146 and #101 regarding the home's practice for the safe storage of topical medications. Both confirmed that it was the home's expectation that prescribed topical medications are stored in the locked clean utility rooms located in each resident care area. The staff further confirmed that prescribed topical medications are not to be stored or left in tub rooms.

An Interview was conducted by Inspector #628 with the Administrator. The Administrator confirmed that it was the home's expectation that prescribed topical medications that are in use are to be stored safely in the locked clean utility rooms located on each resident home area. The Administrator acknowledged that this did not occur, and should have. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked., to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber; specifically, that reassessment of medication included in a physician's order was completed as ordered by the physician.

Inspectors #620 and #625 reviewed an order for medication belonging to resident #025. The order included instructions for further monitoring twice daily for two weeks followed by reassessment.

Inspectors #620 and #625 interviewed staff member #122 who confirmed the electronic order stated the medication was to be reassessed in two weeks. Staff member #122 contacted the pharmacy service provider and stated that they were told the instruction to reassess the medication should have been removed. Staff member #122 then checked the documentation and stated that there was no entry concerning the reassessment of the medication as had been ordered.

Inspectors #620 and #625 reviewed the progress notes and found no documentation of reassessment of the medication order. On the Medication Review Report Physician #150 had reordered the original medication including the reassessment in two weeks. The order for the medication included instructions to reassess in two weeks; the reordered medication order was duplicated verbatim on five quarterly Medication Review Reports.

A review of the resident's health record by Inspector #625 identified that the reassessment of the medication was ordered to occur on six occasions; no reassessment was documented to have occurred.

Inspector #625 spoke with a multidisciplinary team member who confirmed that the reassessment of the medication order had not occurred two weeks after the initial order was written. The multidisciplinary team member stated that it was their role to contact the physician to determine if the order was to continue when medications are ordered with a defined timeline for reassessment; the multidisciplinary team member confirmed that this did not occur.

Inspectors #620 and #625 interviewed the DOC. The DOC confirmed that the documents stated that the medication was to be reassessed in two weeks, and that this had not occurred. The DOC also stated that staff were expected to review orders and follow-up if an error had been identified. The DOC noted that a medication error had occurred and should not have.

The licensee had failed to administer medication to resident #025 in accordance with the prescriber's instructions. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber; specifically that reassessment of medication included in a physician's order is completed as ordered by the physician., to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (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. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

Specifically, that staff failed to store residents' personal hygiene products, in a manner appropriate to minimize the risk of contamination and spread of infection.

Inspector #625 and #153 observed that in the Tub Room of Porcupine Lake Unit there were unlabelled items such as a black comb with accumulation of hair, a pair of used nail clippers, five used deodorant sticks, a used antiseptic mouth wash bottle, a used Dimethicone Protectant cream container, and a used Tena Body Wash container. There was also a shampoo container approximately 30 per cent full on the shower railing with the lid off. Similarly, in the Kamiskotia Lake Unit Tub Room there was a pair of unmarked nail clippers, and one used unlabelled deodorant stick in the cabinet located in the unit tub room.

Inspector #625 interviewed staff member #140, 137,154, and 155, who all confirmed that residents' belongings and personal hygiene items should be labelled and in their rooms. Staff member #140 stated that any items not labelled and found in the tub area are to be discarded. Staff member #155 and #156 stated that Tena Body Wash & shampoo was shared for use with residents. Staff member #155 also stated that staff pours the product onto a washcloth or onto the resident's head to shampoo. Staff

member #155 noted that washcloths are replenished multiple times with Tena Body Wash & shampoo. The staff member further stated that the washcloths were discarded and a new cloth was obtained if they were visibly soiled, depending on the part of the resident's body that was soiled.

Inspector #625 interviewed Administrator #111 who stated that Tena Body Wash & shampoo was shared between staff for multiple residents. The Administrator stated that the pump-lid prevented cross-contamination. They further noted that it was the home's expectation that the lids are kept on the bottles for infection control purposes.

Inspector #625 interviewed staff member #123 who stated that Tena Body Wash & shampoo was used between multiple residents and that there were no concerns with residents sharing bottles as long as the bottle was capped when staff were done using it as the container has a flip cap. The staff member stated that hygiene product bottles should not be stored without a lid. They further noted that staff should be disposing of washcloths in between use and not applying more product to it. The staff member noted that all used hygiene products should have residents' names on them and be labelled and deodorants should not be shared between residents. [s. 229. (4)]

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 ensuring that all staff participate in the implementation of the infection prevention and control program., to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(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 :

1. The licensee failed to ensure that, where bed rails were used, safety issues related to the use of bed rails were addressed, including proper installation of bed side rails.

Inspector #625 inspected a room within the home. Inspector #625 attempted to lower a bed rail and requested the assistance of staff member #126. The staff member stated that the bed rails did not work properly as they swung towards the head of the bed, not towards the foot of the bed. They demonstrated that the rail hit the wall when attempting to lower the rail, stopping the rail from lowering.

Inspector #625 interviewed the staff member #114 who stated that no preventative maintenance was conducted on bed rails but a process was in place for notification and repair of the rails. They also stated that nursing staff would inform the Maintenance Department of bed rail concerns by writing it in the Maintenance Binder located on each unit. Inspector #625 reviewed the Maintenance Binder on Mattagami Lake Household; there was no entry related to the bed rails in a certain room within the home.

Inspector #625 interviewed the Administrator #111. The Administrator accompanied Inspector #625 to a room and the Administrator attempted to lower the rail and was unable to do so as the rail was impeded by the wall. The Administrator stated that the rails had been installed on the incorrect sides of the bed. They stated that the rails had been installed in 2013, when the bed was assembled. They also noted that the bed rail audit completed by the staff member #114 should have included an assessment of the functionality of the bed rail, and did not. [s. 15. (1) (c)]

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that if Residents' Council has advised the licensee of concerns or recommendations that the licensee shall within 10 days of receiving the advice, respond to the Resident's Council in writing.

Inspector #621 reviewed the Residents' Council meeting which identified a concern involving a resident exhibiting a certain behaviour. A review of the Residents' Council meeting minutes failed to mention the identified concern brought forward at the previous month's meeting.

An interview with staff member #116 by Inspector #621 confirmed that the above noted concern was not followed up in writing within 10 days, nor was this item recorded in the Residents' Council meeting minutes. [s. 57. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle included alternative beverage choices at snacks.

Inspector #621 observed that the menu cycle posted in the home did not identify alternate beverage choices offered at snack times.

Staff member #109 stated to Inspector #620 that the menu did not identify beverage options for snacks. An observation of the posted weekly menu revealed that it did not include a snack rotation that incorporated beverage options for morning, afternoon, and evening nourishment passes.

An interview with the staff member #115 confirmed that the snack menu which included food and beverage choices was not posted as part of the three week menu cycle, and should have been. [s. 71. (1) (d)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a verbal complaint was reported, investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint.

On June 19, 2015, the SDM for resident #003 initiated a verbal complaint to the home. A review of resident #003's health care record confirmed that the issue was reported. A review of the Complaint Investigation Form revealed that the complaint investigation was complete. The Complaint Investigation Form did not identify the "Appropriate Discipline" that it was to be forwarded to, as was required by the home's policy. A review of the home's policy confirmed that responses to complaints were to be provided within 10 business days. The form did not detail that any additional follow up occurred in relation to the complaint.

An interview with the Administrator confirmed that a response had not been provided to the SDM within 10 business days. They confirmed that the home's complaint process had not been followed, and should have been. [s. 101. (1) 1.]

Issued on this 22 day of January 2016 (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

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : ALAIN PLANTE (620) - (A1)

Inspection No. / No de l'inspection : 2015_336620_0008 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 029533-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jan 22, 2016;(A1)

Licensee / Titulaire de permis :

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700,
MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD :

EXTENDICARE TIMMINS
62 St-Jean Avenue, TIMMINS, ON, P4R-0A6

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 : Kelly Roy

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To EXTENDICARE (CANADA) INC., 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)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee shall:

a) ensure that all staff responsible for wound care assessments are retrained on the home's policy for wound care assessment, referral, and collaboration;

b) ensure that all staff responsible for performing wound care are retrained on the home's policy for treatment and staging of wounds;

c) ensure that all training related to this order is documented;

d) ensure that resident #010's wound assessment is consistent with regard to location, stage, and presence of wound;

e) develop and implement a monitoring system to ensure that the home's policy is followed with respect to collaboration, and multidisciplinary assessment of wounds.

Grounds / Motifs :

1. The licensee failed to ensure that staff and others involved in different aspects of care collaborated with each other in the assessment of resident #010 so that their assessments were integrated, consistent with, and complemented each other.

Inspector #625 reviewed the Weekly Wound Assessments, an Annual Medical Assessment, and a Head to Toe Skin Assessment for resident #010. The documents revealed that resident #010 had a wound. Resident #010's Weekly Wound Assessments, Annual Medical Assessments, and Head to Toe Skin Assessments revealed that during a 60 day span the wound was documented inconsistently. On one occasion the wound was documented as non-existent. Three times the wound was documented in conflicting locations and on three occasions the wound was documented inconsistently with regard to stage of wound.

Staff member #125 was interviewed by Inspector #625 and stated that resident #010 currently had a wound. The staff member further stated that no Physician's order was in place for the treatment of the wound.

Inspector #625 interviewed Staff member #110 who stated that they had last assessed the resident 59 days earlier, due to the presence of a wound. They stated

that they were required to check an electronic spreadsheet to see if the resident's wound had deteriorated. They also stated they had not checked the spreadsheet for a 62 day period, and should have. Staff member #110 was not aware of the change in the severity of resident #010's wound and should have been.

Inspector #625 interviewed Staff member #123 regarding resident #010's wound. They referred to an electronic wound tracking spreadsheet that indicated the wound originated 65 days earlier. They noted that the Weekly Wound Assessments listed conflicting information for the location and stage of the wound. The Staff member confirmed that the wound was improperly documented in terms of location on numerous occasions. They were unaware that staff were cleansing the wound with normal saline and applying a dressing as observed by Inspector #625. They stated that if resident #010 had a wound treatment being performed it should have been entered into the care plan indicating to refer to the resident's Treatment Administration Record (TAR), where the specific dressing instructions should be listed. They confirmed that there were no instructions in the care plan or the TAR, and should have been.

Inspector #625 interviewed Administrator #111 who stated that staff members were expected to engage a multidisciplinary team to manage wounds. The Administrator was uncertain as to why the interdisciplinary staff were not aware that resident #010's wound had deteriorated. They confirmed that some members of the interdisciplinary staff had not received a referral since the initial referral, and should have.

The assessments and documentation for resident #010's wound was inconsistent with respect to the location of the wound, the stage of the wound and the presence of the wound. Staff and others involved in different aspects of the resident's care had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)] (625)

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

Dec 28, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall:

a) review the RN staffing compliment and make any necessary adjustments to ensure that a RN is present and on duty within the home at all times;

b) review the home's policy and process for replacing absent scheduled RNs to ensure that it is consistent with the requirements under the Long-Term Care Health Act for 24/7 RN coverage;

c) ensure that all staff responsible for replacing absent RNs are retrained on the policy and process for ensuring 24/7 RN services, and that the training is documented.

Ontario

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

Grounds / Motifs :

1. The licensee failed to ensure that at least one RN who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

A record review by Inspector #620 of the RN coverage for a three month period revealed that on the following dates there was no RN on duty within the home during the Night shift (2300-0700 hours): September 23, 2015, September 24, 2015, October 08, 2015, October 14, 2015, and October 18, 2015.

A review of the home's documented process for replacing RNs revealed that if an RN was absent, a part-time or casual RN would be called in. If the call in of the part-time or casual RN was unsuccessful, a full-time RN would be called in. If no RN was available, the position would then be filled by a RPN.

Manager #148 (Manager responsible for staff scheduling) was interviewed by Inspector # 620. The Manager stated that the home replaces an absent RN with RNs if possible but if that was not possible, they replace with an RPN. They indicated that they often struggle to replace RNs if their full time RN staff are absent. The Office Manager stated that they were aware of the requirement to maintain 24 hour RN coverage, and that this had not always occurred.

Inspector # 620 interviewed Administrator #111. The Administrator stated that they were aware that on occasion the home replaces a RN with a RPN if the home was unable to call in a staff RN. The Administrator was aware that the home's written staffing process involved replacing a RN with a RPN. They stated that there was currently no effort to recruit additional RN staff. The Administrator confirmed that they were aware of the requirement to provide 24 hour RN staffing and that this did not always occur, and should have. [s. 8. (3)] (620)

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

Dec 28, 2015

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

Order # / Ordre no : 003

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

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 :

(A1)
The licensee shall:

a) complete a maintenance audit of the entire home and act on the results of the audit to ensure that the home's interior and exterior are maintained in a good state of repair;

b) ensure that a record of remedial maintenance is maintained, and that the record includes the initiation and completion of all remedial maintenance work;

c) ensure that the home's maintenance plan details the scheduling of staff responsible for maintenance of the home;

d) ensure that all staff are retrained on the policy process for reporting maintenance concerns, and that documentation of the training is completed.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Inspector #621 identified maintenance related concerns in numerous areas of the home. In the Porcupine and Big Water Lake Unit there was an abundance of unpainted patch work on the walls. The Big Water Lake Unit also had panels missing on radiators in the lounge and bathrooms. The Mattagami River Unit had one panel of a radiator that was removed and lying on the floor next to the toilet. The Gillies Lake Unit had a large segment of tile missing on the wall and base board was found broken and taped back together.

Further Observation by Inspector # 620 revealed that nine of 11 parking lot lights were not working. Inspector # 620 also identified that the floor covering in a tub room had a seam that was separated, delaminated from the substrate, and contained a two inch depression below the floor covering that was holding water.

Inspector # 620 interviewed staff member #114. They revealed that they were aware that the lighting on the exterior of the home was not currently functional and that it had been in this condition since the early summer of 2015. They confirmed that the wall covering and radiator covers were in disrepair throughout the home. Staff member #114 indicated that the home was having difficulty addressing the maintenance of wall surfaces.

Inspector # 620 interviewed the Administrator. They stated that they were aware that the flooring in a tub room had separated, and was holding water. The Administrator also revealed that they were, "losing ground" in the effort to maintain wall surfaces and radiator covers. The Administrator stated that they did not have enough staff to address the remedial maintenance concerns the home was required to undertake. [s. 15. (2) (c)] (620)

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

Feb 29, 2016(A1)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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
Direction de l'amélioration de la performance et de la conformité
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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 22 day of January 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : ALAIN PLANTE - (A1)

Service Area Office /
Bureau régional de services : Sudbury