Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 21, 2014	2014_196157_0006	O-000131-14	Resident Quality Inspection

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

FOSTERBROOKE
330 KING STREET WEST, NEWCASTLE, ON, L1B-1G9

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

PATRICIA POWERS (157), CHANTAL LAFRENIERE (194), KELLY BURNS (554), WENDY BERRY (102)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 25, 26, 27 and 28, March 3, 4, 5, 6 and 7, 2014

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Associate Director of Care, RAI Coordinator, Business Office Manager, Staff Educator and Resident Services Coordinator, Food Service Manager, Environmental Service Manager, Registered Nurses, Registered Practical Nurses, Personal Supports Workers, Housekeeping Staff, Laundry Staff, Program staff, Cook, Dietary Staff, Pharmacist, President of Residents' Council, President and member of Family Council, Residents and Family members.

During the course of the inspection, the inspector(s) Toured resident care areas including resident rooms, common areas, storage areas, dining areas and bathing facilities. observed provision of resident care, observed staff to resident interactions, reviewed clinical health records for identified residents, reviewed Terms of Reference and minutes of Residents' Council and Family Council, reviewed Infection Prevention and Control polices and procedures, observed Infection Prevention and Control practices, monitored air and water temperatures, monitored lighting levels, reviewed and monitored cleaning procedures, reviewed and monitored laundering and handling of residents' personal clothing, observed cleaning and maintenance of residents' personal items, personal aids and equipment, reviewed and observed medication administration procedures, resident medication administration records, facility medication destruction records, observed medication storage areas, observed meal and snack service and food quality, observed resident activity and recreation programs, reviewed procedures related to and outcomes of resident/family satisfaction surveys, reviewed home policies and procedures related to responsive behaviours, prevention of abuse and neglect, medication management, food services, continence care and bowel management, laundry procedures, management of complaints and suggestions, recreation and activity programming, environmental services, care of personal items, aides and equipment.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency. O. Reg. 79/10, s. 9. (1).
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 :

1. The licensee failed to ensure that all doors leading to stairways were:
i) Kept closed and locked
ii) Equipped with a door access control system that is kept on at all times
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:

During the inspection on March 4, 5 and 6, 2014, 2 resident accessible doors leading from the lower level (basement) corridor into a central stairway:
- Were closed but not locked. The doors are not equipped with a locking system;
- Are not equipped with a door access control system; and
- Are not equipped with an audible door alarm.

The stairway can be accessed without supervision and/or without being detected which is a potential risk to the health, safety and well-being of residents. [s. 9. (1)]

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 O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee failed to ensure that the lighting requirements set out in the LTCHA, O.Reg.79/10, s.18 are maintained:

On March 04, 05 and 06, 2014 illumination levels in resident areas were checked by Inspector #102. A hand held GE light meter was used. The meter was held 3 to 4 feet above the floor surface with all available electric light fixtures turned on. Window coverings were closed when light levels were measured in residents' bedrooms.
- Levels of illumination throughout 1st and 2nd floor residents' bedrooms, which in some bedrooms also includes entrance vestibules and alcoves containing clothes closets, were less than 50% of the required lighting level of 215.28 lux.
- Levels of illumination throughout 1st and 2nd floor program, lounge and dining areas were less than 25% to 50% of the required lighting level of 215.28 lux.
- Levels of illumination provided in the 1st and 2nd floor corridors was identified to be less than 25% to 50 % of the required illumination level of 215.28 lux of continuous, consistent lighting throughout the majority of each corridor.
- Levels of illumination provided in the 1st floor tub and shower room was less than 50% of the minimum required lighting level of 215.28 lux.
- Levels of illumination were greater than 215.28 lux underneath the ceiling mounted fluorescent light fixtures and also in the vicinity of the nursing station desks.

Low levels of lighting are a potential risk to the health, comfort, safety and well- being of residents. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments; to conduct assessments; to provide treatments.
Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility, nutritional intake, and overall quality of life. [s. 18.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a comfortable easy chair is provided for every resident in the resident's bedroom:

Tours of resident rooms on February 25, 26, March 3 and 4, 2014 identified that a comfortable easy chair is not provided for every resident in the resident's bedroom. Two family members indicated to inspector #554, that they do not have anywhere to sit when visiting the resident.
Examples:
Room 101 - 4 bed room - one easy chair and two folding chairs provided
Room 104 - 4 bed room - 2 easy chairs provided, one folding chair
Room 106 - 4 bed room - 2 easy chairs provided
Room 109 - 4 bed room - 2 folding chairs provided
Room 209 - 4 bed room - No easy chairs provided
Room 210 - 2 bed room - 1 easy chair provided
Room 212 - 4 bed room - no easy chair provided
Room 217 - 4 bed room - 1 easy chair provided
Room 219 - 4 bed room - 1 easy chair provided [s. 12. (2) (e)]

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 a comfortable easy chair is provided for every resident in the resident's bedroom, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary:

Floor surfaces throughout the 1st and 2nd floor corridors and the majority of resident rooms on the 1st floor were observed to be covered with a film/residue. Sand and salt from the exterior parking lot and walkway is being tracked into the home. Floor cleaning and washing efforts made by the housekeeping staff to remove the residue from the floor surfaces in resident areas were not successful. Bedroom floor surfaces observed following cleaning by staff using a string mop and bucket containing a pre-measured floor cleaning solution continued to have a residue evident on the floor surface which, in some areas, could be wiped off.

A shower chair located in the 2nd floor tub/shower room was observed to be in use with a soiled/stained nylon type fabric back. Metal or aluminum connectors for the flip up arms, also located on the backrest area of the chair, were observed to have a scale or corrosion build up which would affect the ability to clean and disinfect the chair's surfaces. [s. 15. (2) (a)]

2. Inspector #194 observed the following;

Resident #134 wheelchair was soiled
Resident #11 wheelchair was soiled
Resident #108 walker was dirty, soiled with dried food
Resident #09 wheelchair was soiled

The Director of Care(DOC) reported that a new schedule has been established and is to be implemented in the near future which assigns two Personal Support Workers (PSW)to be allocated hours on a monthly basis for cleaning of wheelchairs and walkers. [s. 15. (2) (a)]

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

- Exhaust fans were observed to be non functional or malfunctioning in several areas, which may negatively impact the air exchange in the home: 1st floor soiled utility room, washrooms that adjoin rooms 102, 111, 114, 204.
- Many window screens are bent and do not fit securely in window frames creating a potential entry point for insects in warmer weather.
- Hardware is missing from window opener mechanisms at a number of windows in resident and common areas throughout the home.
- Aluminum type grab bars connected to toilets and toilet seats were loose in washrooms that adjoin rooms 201, 207, 208, 210, 117, 104.
- Foot boards on several beds were loose. For example, one in each of rooms 107, 109 and 204.
- Wood veneer was jagged and rough on lower surfaces of doors to ensuite washrooms in rooms 104 and 109.
- Clothes closet doors could not be opened and/or were misaligned in rooms 109, 111, 116, 218, 116 and on one bedside table in room 103.
- Lower walls in the majority of residents' bedrooms and ensuite washrooms are scarred and/or gouged leaving non intact surfaces that can not be cleaned effectively;
- Toilet paper holders were missing in the tub room on first and second floor. Excessive direct hand contact with rolls of toilet paper is a potential cross infection hazard.
- Bedroom windows are "fogged" between the double panes of glass indicating that seals on the windows have been compromised in rooms 119 and 210.

- Grout and sealant at the base of the toilet in the washroom that adjoins room 217 is discolored/blackened and/or soiled and the surfaces have degraded. The washroom is highly malodourous.

Furnishings, equipment and building surfaces that are not maintained in a safe condition and a good state of repair are a potential risk to the health, comfort, safety and well being of residents. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are:
- kept clean and sanitary
- maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that each resident's personal items are labelled:

Inspector #554 observed the following;
- Room 210 - 2 bed room - toothbrush and bedpan in the shared washroom were not labelled
- Room 212 - 4 bed room - bedpan in shared washroom was not labelled
- Room 217 - 4 bed room - toothbrush in shared washroom was not labelled
- Room 218 - 4 bed room - toothbrush and basin in shared washroom were not labelled
- Room 204 - 4 bed room - hairbrush in shared washroom was not labelled
- Room 209 - 4 bed room - hairbrush in shared washroom was not labelled
- Room 219 – 4 bed room – bedpan and urinal in shared washroom were not labelled

Staff member #106 indicated that the expectation in the home is that all personal care items are to be labelled for individual resident use.

On March 6, 2014, the DOC indicated that it is an expectation that all personal care and grooming supplies are to be labelled. Labelling is to be completed on admission, with any new supplies and as required. [s. 37. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident's personal items are labelled, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The licensee failed ensure that the resident's substitute decision maker was notified of the resident's personal aids or equipment was not in good working order or required repair:

Resident #56 - Wheelchair arm rests were observed to be cracked and peeling.
Resident #78 - Wheelchair right brake is not working and arms rests were observed to be cracked and peeling. The right brake on the resident's walker is not working
Resident #84 - Wheelchair right brake is not working
Resident #90 - Wheelchair left hand rest observed to be cracked and peeling
Resident #127 - Wheelchair right brake is not working. [s. 38. (a)]

2. Interviews with registered nursing staff on the first and second floors confirmed the following practice for wheelchair repair in the home:
- Staff are required to complete a "Motion Specialties- Service Request Form for Client Equipment". The form, when completed, is placed in the Motion Specialties binder at the nursing station. A review of the binder on March 6, 2014 indicated that the required repairs identified by the inspector have not been placed in the designated binder to ensure follow up.
- Staff are required to notify families of services being requested.

The Director of Care (DOC) confirmed the accuracy of the above noted procedures communicated by the registered nursing staff.

The Power of Attorney (POA)for an identified resident was interviewed on March 6, 2014. He stated that he had been contacted about repairs that were to be completed on the chair, but also stated that he was aware that the chair required more attention. [s. 38. (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:
- the resident's Substitute Decision Maker is notified when the resident's personal aids or equipment are not in good working order and require repair
- internal procedures to ensure the completion of required repairs are complied with, to be implemented voluntarily.

WN #7: 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).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care or a resident or the operation of the home is investigated and resolved, where possible, and a response provided within 10 business days of the receipt of the complaint:

Related to resident #92:
- Resident #92 stated in an interview with the inspector that the resident is "finding it

difficult to sleep at night due to staff talking loudly". Resident stated that this concern has been brought to the attention of the Associate Director of Care (ADOC) several times without resolve.
- Residents' Council minutes indicate that this concern has been raised on a number of occasions.
- The Executive Director (ED), in an interview with inspector #554, indicated awareness of the complaints from Resident #92 and Residents' Council. The ED confirmed that at this time, there has been no resolution to the night noise concerns.
- The ED, in an interview on March 5, 2014, confirmed that no response had been provided to resident #92 or to the Residents'Council Members for concerns related to the noise at night.

Related to Residents #07 and #117:
- During a dining room observation on March 3rd and March 4th, 2014, Resident's #07 and #117 indicated to the inspector that they are tired of sitting from 1130 hrs until 1230 hrs or later waiting for their lunch. Both residents stated that sitting for an extended period of time waiting for meals to be served is very upsetting and feel that "something has to be done". The residents indicated that they have voiced concern about wait times to staff on a number of occasions without resolution.
- Residents' Council minutes indicate that this concern has been raised on a number of occasions.
- Cook #111 stated that she is unable to do anything about the wait times and advised that staff try to rotate meal service times at lunch and supper.
- In interviews conducted with the Food Service Manager(FSM) and ED, both indicated that the home does its best to avoid wait times but at this time, nothing can be done to resolve this concern.
- The ED indicated that the home is investigating servery changes for the future.
- The ED, in an interview on March 5, 2014, confirmed that no response had been provided to residents #07, #117 or to the Residents' Council Members for concerns related to wait times for meal service. [s. 101. (1) 1.]

2. The Licensee failed to ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint (including date, action taken, time frames for actions to be taken), any follow up action required, final resolution if any, dates on which response was provided to the complainant and a description of the response:
- A review of the home's Complaint Log binder, for the period of September 10, 2013

to March 5, 2014 indicated that there is no documented record of complaints received from residents #92, #07 and #117 related to concerns of noise from staff at night and meal service wait times.
- The Licensee failed to indicate dates the complaints were received, action taken to resolve the complaint and the final resolution, if any, for the complaints.
- The ED, in an interview on March 5, 2014, indicated that the identified complaints had not been documented and a response been not been provided to the residents or Residents' Council.
- The ED confirmed that the expressed complaints and concerns related to noise levels at night and meal service wait times remain outstanding. [s. 101. (2)]

3. The Licensee failed to ensure that a documented record of complaints is reviewed and analyzed for trends at least quarterly, that the results of the review and analysis are taken into account in determining what improvements are required in the home and a written record of each review is kept:

- A review of the home's Complaints Log binder for the period January 1, 2013 to December 31, 2013, failed to demonstrate that a quarterly review or analysis was completed by the licensee.
- The ED confirmed that the home currently does not review or analyze complaints for trends on a quarterly basis.
- The ED indicated that this is an area identified as requiring improvement for 2014. [s. 101. (3)]

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 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:
- the complaint shall be investigated and resolved, where possible, and a response provided within 10 business days of the receipt of the complaint
- if the complaint cannot be investigated and resolved with 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days
- a written response shall be made to the person making the complaint identifying what has been done to resolve the complaint or that the licensee has found the complaint to be unfounded and the reasons for that belief
- A documented record of complaints is reviewed and analyzed for trends at least quarterly, the results of the review and analysis are taken into account in determining what improvements are required in the home and a written record of each review is kept, to be implemented voluntarily.

WN #8: 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 are stored in an area or a medication cart that is secure and locked:

Related to Resident #92:
- Inspector #554 observed that prescription medications were stored on an open shelf in resident #92's room.
- Resident #92 indicated that the above noted medications had been in the resident's possession since November 8, 2013 when they were prescribed. The resident confirmed that these medications are stored on the shelf beside the bed. The resident did not have access to a locked cabinet or drawer in which to safely store the identified medications.
- The DOC indicated that she had no awareness of medications being stored in resident #92's room and confirmed that Resident #92 did not have access to a locked drawer or cabinet for safe medication storage. [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 #9: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The Licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident:

Related to Resident #92:
- Prescription medications were observed on a shelf in Resident #92's room. These medications were discontinued by the physician on January 1, 2014.
- Resident #92 confirmed continued use of both prescription medications and the resident confirmed that they are self administered.
- Registered nursing staff interviewed indicated that they had no awareness of Resident #92 having and using the medicated treatment creams.
- The ADOC indicated that the expectation is that all medications and treatments that have been discontinued and are no longer in use, are removed from use and placed into drug destruction for appropriate disposal.
- The DOC indicated no knowledge of this resident being in possession and self administering discontinued prescription treatment creams. [s. 131. (1)]

2. The Licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident:

Related to Resident #92:
- Prescription medications were observed stored on an open shelf in Resident #092's room.
- Resident #92 indicated self administration of the medications. The physician's order does not direct self administration of the medications.
- There is no current physician's order for identified medications.

Registered nursing staff interviewed confirmed that they were not aware of resident #92 self administering medications with the exception of one identified medication.
- A review of progress notes and assessments completed by registered nursing staff during the period of November 1, 2013 to March 3, 2014 failed to demonstrate that an assessment for self administration of medications was completed for Resident #92.
- The ADOC and DOC informed the inspector they are not aware of any current practice of self administration of medications occurring within the home. [s. 131. (5)]

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:
- no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident
- no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the licensee is required to have, institute or otherwise put in place any plan, policy, protocol or procedure, strategy or system, the plan, policy, protocol or procedure, strategy or system is complied with. [s. 8. (1)]

2. As per LTCHA,c.8, s.86(1), the home shall have an Infection Prevention and Control Program that complies with the requirements of O.Reg.79/10s.229 related to infection prevention and control.

The home's policy "Immunization of Residents", IPC-I-10, dated April 2013, directs the following related to immunizations:
- Document each resident's vaccine administration information in the resident's health record.
- Documentation in the resident's health record must include:

- the date and time the vaccine administered
- the trade name of the product
- manufacturer and lot number
- dose
- vaccination site and route
- the name and title of the person administering the vaccine
- the name and title of the person administering the vaccine
- any untoward occurrences at the time of immunization (eg resident afraid, fainting)

Related to resident #01:
- Resident #01 was admitted to the home on an identified date. An "Admission Order" check list was completed and signed by the Physician and registered nursing staff.
- The admission orders identify that resident #01 requires the following:
1. TB test on admission (2 step Mantoux)
2. TD vaccine
3 Pneumovax (if not given elsewhere)
4. Annual influenza vaccine with consent, if no contraindications.

The licensee failed to comply with the established policy when documentation in the health record for resident #01 failed to identify:
- the trade name of the product
- the manufacturer and lot number
- the dose
- the vaccination site and route [s. 8. (1)]

3. As per O.Reg.79/10s.114(2), the home is required to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home's policy, "Medication Disposal - Narcotics", 5.8.1, directs the following related to drug destruction:
- The drug destruction and disposal team, consisting of the Director of Care or designate and the Pharmacy are to document the following on the drug record; date of removal from drug storage, resident name, prescription number, reason for destruction, date drug destroyed, names of persons destroying the drug and the manner of destruction of the drug.

Drug destruction and disposal was last completed on February 27, 2014, as indicated by registered nursing staff interviewed.

Drug destruction and disposal records for February 27, 2014, failed to identify the reason for the destruction and/or the manner of destruction of drugs for the following residents:
- Resident #018
- Resident #073
- Resident #019
- Resident #018

In an interview, the ADOC indicated that the reason for destruction and manner of destruction should have been identified on the individual resident narcotic record.

In an interview, the Pharmacy Consultant further confirmed that the reason for destruction and the manner of destruction is to be recorded on each individual resident narcotic record. [s. 8. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep:

Related to Resident #54:
- A family member for Resident #54, indicated that the resident's sleep and wake patterns were not individualized and are often inconsistent related to changes in staff from shift to shift.
- The family member stated that the resident is frequently wakened by staff in order to perform care and often the resident was not awake in time to attend an identified program. The program coordinator confirmed that the resident has not attended the program in the last month as the resident was not out of bed in time to attend.
- Interviews with identified PSW's indicated that they were not aware of the resident's sleep/wake pattern or preferences.
- The written Plan of Care for Resident #54, fails to provide any direction/focus related to desired bedtime and rest routines.

In an interview, identified PSW's reported that there are no specific bedtime or rest periods individualized for residents. They advised that residents are placed in bed if they appear tired or as staff "get to their rooms" in the evening.

The ADOC confirmed that plans of care do not identify resident's desired bed times and rest routines. [s. 41.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence, and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require. [s. 51. (2) (a)]

2. Related to Resident #130:
- MDS documentation indicates a significant change in status assessment was initiated for Resident #130. The nature of the problem is identified in the assessment as the resident being frequently incontinent and requiring the use of an incontinent product; possible reversible conditions to be considered were identified as 'delirium'.
- RAP documentation identified the resident as being on a restorative toileting program.
- Interviews with identified PSW's, indicated that Resident #130 was frequently incontinent, despite toileting. The staff members indicated Resident #130 may have had more episodes of urinary incontinence around the time resident was sick but stated they could not be certain.
- In an interview the ADOC advised that a continence assessment should have been completed with the significant change in status for this resident.

The clinical health record for Resident #130 indicates that a Continence Assessment has not been completed since the time of admission. [s. 51. (2) (a)]

3. Related to Resident #70:
- MDS documentation indicates a significant change in status assessment was initiated for Resident #70. The nature of the problem is identified in the assessment as the resident being frequently incontinent, requiring the use of an incontinent product; possible reversible conditions to be considered are identified as 'delirium'.
- MDS – RAPs documentation, also indicates that the "resident's bladder incontinence has improved over the last quarter" resulting in conflicting MDS data being provided in the December 3, 2013 assessment.
- Progress notes for an identified period for Resident #70, did not identify that the resident was identified by physician or nurse practitioner as having an acute delirium or illness which would have contributed to changes in resident's functional status.
- In an interview, identified PSW's indicated that they had "no awareness of a significant change in urinary incontinence or improvement in continence" for Resident

#70, despite the MDS assessment indicating there was a significant change. Staff indicated that the resident is frequently incontinent, despite toileting.
- The ADOC stated that she was not aware of any changes in Resident #70's health status or functional abilities. The ADOC confirmed that if the MDS data is correct, a continence assessment should have been completed for the resident identified as having a significant change in status.
- There was no Continence Assessment completed for Resident #70. [s. 51. (2) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies were developed and implemented to respond to the responsive behaviours demonstrated by Resident #09:

- Two residents interviewed, expressed fear of being hurt as a result of Resident #09's behaviours.
- Registered nursing staff, PSW and ADOC interviewed confirmed that Resident #09 would kick or push co-resident's if they got in the way when the resident was moving about in the wheelchair.
- The Plan of Care for Resident #09 states that resident has a tendency to propel the wheelchair through congested area and needs encouragement and cuing not to collide with other residents and obstacles. The plan of care fails to provide strategies to respond to the resident's responsive behaviour. [s. 53. (4) (b)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations:

The ED, interviewed March 4, 2013 confirmed that written replies to concerns or recommendations from Residents' Council are not provided.
The President of Residents' Council, confirmed that a written reply to concerns and recommendations is not received from the licensee.

Residents' Council minutes for September 10, 2013, October 8, 2013, November 12, 2013, December 10, 2013, January 8, 2014, February 10, 2014 indicate that resident voiced concerns:
- related noise in the hallways and in their rooms at night; and
- residents stated they do not appreciate the topics of conversation that are being discussed by staff in the presence of residents

Residents' Council minutes for October 8, 2013 and November 12, 2013, indicate that residents voiced concerns related to the length of time they are required to sit in the dining room before their meal is served.

Residents' Council minutes for November 12, 2013, indicate that residents voiced concerns related cold temperatures in some rooms.

There is no evidence of a written reply to concerns expressed by Residents' Council members. [s. 57. (2)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations:

A family member who has attended Family Council meetings in 2013/2014 confirmed that written replies to concerns and suggestions are not provided.

The ED, interviewed March 4, 2014 confirmed that written responses are not provided to Family Council.

Family Council meeting minutes indicate the following:

September 25, 2013 - Council members expressed concern that wheelchairs and walkers are not being cleaned and asked what the cleaning schedule is for washrooms, how often they are cleaned and who audits them.

There is no evidence of a written reply to concerns expressed by Family Council members. [s. 60. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that the food production system provides for communication to residents and staff of any menu substitutions;

Monday March 3, 2014 - noon meal:
- The daily and weekly posted menu indicated that beet and onion salad was to be served.
- Stewed tomatoes were observed to be served in place of the beet and onion salad.

The Cook responsible for the noon meal on March 3, 2014, indicated that there were no beets available to serve.

Four residents interviewed indicated that the home frequently changes the posted menu without communicating the substitutions.

Food Services Manager(FSM), in an interview on Friday March 5, 2014, indicated that menu changes/substitutions are made to the food production sheets, but not recorded on the posted daily or weekly menus and accordingly, are not communicated to residents. [s. 72. (2) (f)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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,
(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; O. Reg. 79/10, s. 87 (2).

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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented for cleaning of the home;
- Procedures were not implemented by nursing staff to clean and disinfect the 2nd floor bath tub following each bath.
- Manufacturers' specifications for the cleaning and disinfection of the ARJO tub are provided but were not followed.
- The disinfectant product container located within the tub's dispensing system compartment was observed to be empty on consecutive days that the bath was in use: the afternoon of March 6, 2014 and the morning of March 7, 2014. Staff were not able to identify who is responsible for ensuring that the disinfecting solution is provided and available for use. [s. 87. (2) (b)]

2. The licensee failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odors;
- Procedures have not been implemented to address offensive lingering malodours that were evident in a number of residents' ensuite washrooms. For example on consecutive days of the inspection, urine type malodours were present in washrooms that adjoin rooms 111, 114, 119, 217. [s. 87. (2) (d)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #901	2011_041103_0005	157

Issued on this 24th day of March, 2014

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

CHANTAL LAFRENIERE (#194)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PATRICIA POWERS (157), CHANTAL LAFRENIERE (194), KELLY BURNS (554), WENDY BERRY (102)
Inspection No. / No de l'inspection :	2014_196157_0006
Log No. / Registre no:	O-000131-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 21, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	FOSTERBROOKE 330 KING STREET WEST, NEWCASTLE, ON, L1B-1G9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHARLENE SMITH

To REVERA LONG TERM CARE 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 :

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

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

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

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

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

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

Order / Ordre :

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

Locking systems connected to doors must comply with all applicable Fire and/or Building code requirements.

Grounds / Motifs :

1. During the inspection on March 4, 5 and 6, 2014, 2 resident accessible doors leading from the lower level (basement) corridor into a central stairway:
• Were closed but not locked. The doors are not equipped with a locking system;
• are not equipped with a door access control system; and
• are not equipped with an audible door alarm.
The stairway can be accessed without supervision and/or without being detected which is a potential risk to the health, safety and well-being of residents.
(102)

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

The licensee will ensure that required levels of lighting are provided in all areas of the long term care home including:
• A minimum of 215.28 lux of continuous consistent lighting in corridors;
• A minimum level of 215.28 lux in all residents' bedrooms, program/lounge space, dining areas, washrooms and tub and shower rooms.
The licensee will provide a written progress report indicate the status of the lighting levels by October 1, 2014. This progress report must be submitted in writing to the MOHLTC, Attention: Wendy Berry, Fax (613)569-9670.

Grounds / Motifs :

1. On March 04, 05 and 06, 2014 illumination levels in resident areas were checked by Inspector 102. A hand held GE light meter was used. The meter was held 3 to 4 feet above the floor surface with all available electric light fixtures turned on. Window coverings were closed when light levels were measured in residents' bedrooms.
Levels of illumination throughout 1st and 2nd floor residents' bedrooms, which in some bedrooms also includes entrance vestibules and alcoves containing clothes closets, were less than 50% of the required lighting level of 215.28 lux.
Levels of illumination throughout 1st and 2nd floor program, lounge and dining areas were less than 25% to 50% of the required lighting level of 215.28 lux.
The levels of illumination provided in the 1st and 2nd floor corridors was identified to be less than 25% to 50 % of the required illumination level of 215.28 lux of continuous, consistent lighting throughout the majority of each corridor.
The level of illumination was greater than 215.28 lux underneath the ceiling mounted fluorescent light fixtures and also in the vicinity of the nursing station desks.
The level of illumination provided in the 1st floor tub and shower room was less than 50% of the minimum required lighting level of 215.28 lux.
Low levels of lighting are a potential risk to the health, comfort, safety and well-being of residents. Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to residents including: the distribution or application of prescribed drugs and treatments; to conduct assessments; to provide treatments. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility, nutritional intake, and overall quality of life.

(102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 01, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Ontario

Ministry of Health and Long-Term Care

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of March, 2014

Signature of Inspector / Signature de l'inspecteur : PER: CHANTAL LAFRENIERE

Name of Inspector / Nom de l'inspecteur : PATRICIA POWERS

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