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
Aug 07, 2015;	2014_327570_0018 (A2)	O-000925-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND
983 Burnham Street COBOURG ON K9A 5J6

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

GOLDEN PLOUGH LODGE
983 BURNHAM STREET COBOURG ON K9A 5J6

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

SAMI JAROUR (570) - (A2)

Amended Inspection Summary/Résumé de l’inspection modifié

The Licensee requested an extension to the compliance date for Compliance Order (CO) # 003, O.reg. 79/10, s. 18 related to lighting. The date has been amended to July 31, 2016 to complete the work.

The licensee will provide a written progress report indicate the status of the lighting levels by February 28, 2016. This progress report must be submitted in writing to the MOHLTC, Attention: Sami Jarour, Fax (613)569-9670.

Issued on this 7 day of August 2015 (A2)

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

Original report signed by the inspector.

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SAMI JAROUR (570) - (A2)

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): September 22-26, 29, 30, October 01-02, 2014.

During this inspection, a critical incident intake (log #000358-14) and two complaint intakes (Log #O-000909-14 and Log #O-000576-14) were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), two Associates Director of Care (ADOC), Resident and Family Services Manager, Life Enrichment Aides, Physiotherapist, Residents, Families, Resident Council President, Family Council Secretary, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Service Manager (ESM), Housekeeping staff.

During the course of the inspection, the inspector(s) toured the home, reviewed health care records of residents, observed meal services, reviewed meeting minutes (for Residents & Family Councils), reviewed the homes policies (Prevention, Reporting and Elimination of Elder Abuse, Infection Control Program, Immunization, Skin Care Program - Specialized Skin Care products, Self Medication-Bedside Storage of Medication, Bowel Care, Cleaning Occupied Isolation Unit, Falls Management, Restraints).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

20 WN(s)
9 VPC(s)
6 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 O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimeters (cm).

During the inspection commencing on September 22, 2014, many resident accessible windows were identified that opened to a width greater than 15 cm.:
-14 bedroom windows were identified in an identified home area that open to a width of approximately 30 cm.
- several windows in an identified home area TV Lounge, tub room and the lounge by an identified resident's room open more than 15 cm.
-8 windows in the auditorium and 4 windows in the chapel have openable areas between approximately 24 and 29 cm.

Critical Incident Report was received and identified that on an identified date a resident was found outside of the LTC home. The CIR report states that " the security guard found a window in an identified lounge that had been opened quite wide (the restrictor had broken) and the screen had been pushed out and was lying on the ground." It was further identified in the CIR that the following actions were taken to prevent recurrence of missing resident: 'The window restrictors were replaced in all lounge windows and all other resident accessible windows are being checked to ensure the restrictors are in good working order."

Resident accessible windows that do not have openable areas restricted to a maximum of 15 cm present a potential risk to the health, safety and well being of residents. [s. 16.]

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. 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 resident staff communication and response system is not available at a number of bath
and shower locations used by residents:
-McMillan Cottage tub rooms #3, #4
-McMillan Garden tub room # 2
Note: all tub rooms were not checked.

The lack of availability of the resident staff communication and response system at baths and showers is a potential safety risk to residents. [s. 17. (1) (d)]

2. The resident staff communication and response system is not available in every area accessible by residents. It was noted that the lower floor residents' laundry room is not equipped with resident staff communication and response system. [s. 17. (1) (e)]

3. The resident staff communication and response system does not clearly indicate when activated where the signal is coming from:
- in the McMillan Cottage resident home area, room numbers located next to each bedroom door do not correspond to the visual display on the call system panel located within the nursing station; for
example: a signal activated from an identified resident's room identifies as a different resident's room on the panel.

- in the McMillan Cottage resident home area, a signal activated from the dining room is indicated only within the nursing station. The signal is not audible or visible to staff outside of the nursing station.
-the resident staff communication and response system provided in resident accessible communal areas and washrooms located in the vicinity of the main entrance closest to Burnham street alert only on an audio visual enunciator located within the Blacklock Cottage secure resident home area.
-the resident staff communication and response system provided within the Blacklock Cottage secure resident home area visually displays activated signals from bedrooms, washrooms, and the tubroom on corridor dome lights within the wing. The audio visual enunciator panel for the home area is located in the Symons 2 home area on an upper floor of the home.

The resident staff communication and response system is to clearly indicate where activated signals are coming from to facilitate a prompt staff response to calls for assistance from residents, staff and visitors. [s. 17. (1) (f)]

4. The resident staff communication and response system provided in Golden Plough Lodge is an audio visual system that primarily uses sound to alert staff when a call has been activated on the system.

During the inspection on September 25, 26 and October 01, 2014, the resident staff communication and response system was not audible to staff in the corridor in the McMillan Cottage resident home area in the vicinity of the lounge and identified residents' rooms. The dining room signal is not audible to staff, other than in the immediate vicinity of the nursing station.

In Blacklock Cottage, the system provided in the majority of resident areas, including bedrooms, washrooms, etc., is not audible to staff within the resident home area. A call that is activated on the
system, illuminates a dome light that is located in the corridor outside of the calling location. The call also activates on an audio visual enunciator panel that is located at a nursing station on an upper
floor of the home, in the Symons 2 resident home area. Nursing staff identified that staff from Symons 2 "will call down, if bell not answered in a timely manner".

During the inspection on September 30, 2014 it was identified that an operational audio visual enunciator for the resident staff communication and response system is provided within the Blacklock Cottage nursing station for the games room that is

located within the home area and for the resident accessible communal areas which are located outside of this home area, on the main floor near the Burnham Street entrance and auditorium. Activated calls for these communal areas are audible to staff only within Blacklock Cottage.

The resident staff communication and response system is not properly calibrated so that the level of
sound is audible to staff.

The resident staff communication and response system is an essential safety system to support the health, comfort, safety and well being of residents. Lack of function, availability or accessibility of the system is a potential risk to residents. [s. 17. (1) (g)]

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. 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. On September 25, 26 and 30, 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 and warmed up.

Levels of illumination throughout the majority of residents’ ensuite washrooms were less than 50% to 75% of the required lighting level of 215.28 lux.(Blacklock House ensuite washrooms excluded);

Levels of illumination throughout a number of program, lounge and dining areas were less than 50% to 75% of the required lighting level of 215.28 lux including: Blacklock Cottage dining room; McMillan Cottage dining room; TV lounge in McMillan Cottage; Symons Cottage lounge.

The levels of illumination provided in some areas in the Symons and McMillan upper and lower floor corridors were identified to range from less than 50% to 75% of the required illumination level of 215.28 lux of continuous, consistent lighting; for example: Symons 2 corridor in the vicinity of the nursing station near identified residents' rooms; McMillan Garden corridor in the vicinity of identified residents' rooms and near the entrance to the dining room; McMillan Cottage corridor section that extends from the hair salon and tubroom #3 through to the dining room and nearby separation doors.

A minimum illumination level of 322.92 lux of continuous, consistent lighting is not provided throughout the 2 stairways on the east side of the building that run between the McMillan and Symons home areas. The illumination level ranged from less than 50% to 75% of the requirement.

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

(A2)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that seat belt restraints are applied safely and in accordance with Physiotherapist's directions (in absence of Manufactures instructions) in the home.

On September 23, 2014 Resident #17 was observed by inspector to be sitting in the wheelchair with a seat belt in place. The seat belt was found to be fastened, loosely lying in the resident's lap. RPN #100 stated that Resident #17 is pulling on the seat belt causing it to loosen.

Physiotherapist (PT) stated that when applying a seat belt, all staff should allow for approximately one inch space between the resident's body and the seat belt.

ADOC #111 stated the home had no manufactures instructions for restraints and that the PT was providing directions for restraint applications.

On September 23, 2014 PT assessed the seat belt for Resident #17 and found it to be loose, giving direction to staff that the seat belt was to be removed, until vendor could fix the belt to prevent it from sliding.

On September 25, 2014 the seat belt for Resident #17 had been fixed by vendor and was no longer able to be pulled causing it to be loose.

Review of Resident #17’s current plan of care identifies the following for restraints: Use of an external device for prevention of injury to self characterized by high risk for injury due to falls, impaired mobility, device used is (seat belt).

Registered staff interviewed stated that Resident #17 would attempt to stand, the seat belt not being properly fastened places the resident at high risk for falls and potential for harm related to strangulation.

On September 29, 2014 Resident #39 was observed by inspector #194 to be sitting in the wheelchair with a seat belt in place. The seat belt was found to be fastened, loosely lying in the resident's lap. RN #108 and RPN #102 stated that the seat belt for Resident #39 was not applied properly. PSW #118 and #119 stated that Resident #39 is pulling on the seat belt causing it to loosen. PSW #118 was able to re loop the seat belt to include the safety clip, which had not been in place at time of observation. The seat belt is now fastened in a manner that the resident cannot loosen.

On September 30, 2014 at 09:40 hrs Resident #39 was observed by inspector #194 to be sitting in the breeze way, in the wheelchair with a seat belt in place. The seat belt was found to have a four inch gap between the belt and the resident's abdomen.

On September 30, 2014 at 09:50 hrs PT was located and seat belt was assessed. PT stated that the seat belt was too loose on the resident and proceeded to tighten the belt. PT stated that education has been provided to staff on how to check to ensure that seat belts are properly fastened.

On September 30, 2014 at 10:00 hrs PSW #122 stated that when assisting Resident #39 with care needs today, a safety check was completed for the resident's seat belt at 09:30 hrs and that the belt was properly fastened.

Review of Resident #’39’s current plan of care identifies the following for restraints: Use of an external device for prevention of injury to self or to others characterized by high risk for injury/falls; device used is lap belt in Broda chair; needs seat belt related to loss of balance, and an identified medical condition.

PSW staff interviewed stated that Resident #39 would attempt to stand, the seat belt

not being properly fastened places the resident at high risk for falls and potential for harm related to strangulation.

Furthermore, as per WN #20 of the inspection report, the licensee failed to ensure that:
- an analysis of the restraining of resident by use of a physical device is undertaken on a monthly basis.
- an annual evaluation is conducted to determine the effectiveness of the restraint policy.

During an interview, RN #106 stated that no monthly analysis of restraints were being completed in the home.

During an interview, ADOC #111 stated that at this time the home was not completing monthly analysis of the restraints in the home and that the annual evaluation of the program had not been completed. [s. 110. (1) 1.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

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

Findings/Faits saillants :

1. High temperature hot water dispensing equipment is accessible to residents on a non- secure, former servery counter top, adjacent to the kitchen on the lower level of the home. During the inspection on September 26, 2014 the temperature of hot water dispensed into a cup from the "Bunn" counter top dispensing unit was 73 degrees Celsius.

The licensee has not ensured that the home is a safe environment for its residents. Access to the hot water dispensing equipment is a potential safety risk to residents. [s. 5.]

2. On September 29, 2014 at approximately 13:00 hrs inspector #166 observed Resident #57 on a floor mat at bedside. The resident's bed was in the lowest position and the 1/4 side rail was in the up position. The resident's whole body was writhing uncontrollably, the resident's head was hitting the bed frame. The resident's movements caused the resident to twist on the floor causing the right leg to get caught in an electrical cord that was plugged into the wall. The cord that was attached to a radio became taunt around the resident's right leg due to the resident's movements, the radio started to move off the bedside table towards the resident.

Inspector #166 called to a housekeeper, who was in the corridor for assistance. Inspector #166 unplugged the cord from the wall and removed the cord from the resident's leg and moved the bedside table away from the resident. The housekeeping staff called a registered staff, who came to assist the resident. [s. 5.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by assessing Resident #57's living environment to address potential safety risks related the resident's medical condition, to be implemented voluntarily.

WN #6: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that Infection Prevention and Control program evaluated and updated at least annually.

During an interview, ADOC #111 who is responsible for the infection control practices in the home, stated that the annual Infection Prevention and Control program evaluation had not been completed. [s. 229. (2) (d)]

2. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

PSW #118 was interviewed and stated carrying in own uniform, a nail clipper for resident use. The PSW stated that the nail clipper is disinfected by using the hand sanitizer solution of alcohol wipes.

Observed in an identified resident's room with a shared bathroom an oxygen Concentrator with nasal prong tubing was noted in the bathroom in close proximity to a commode chair.

During a medication administration, RPN #107 was noted to not complete hand hygiene prior to or after administration of insulin and oral medications.

Staff #137 stated to inspector #194 that she/he was informed of outbreak declared on October 1, 2014 by RPN when arrived on the Blacklock Cottage unit. Staff #137 stated “its not a serious one" and being aware of one resident affected “pointing up the hall". Staff #137 indicated that there was no increased cleaning requirements related to the outbreak status in the unit and was not told to increase cleaning at this time.

Interview with Environmental Service Clerk #138 was conducted on October 2, 2014 indicated the home had a policy related to cleaning requirements in an outbreak situation and the Environmental Service Manager and herself are responsible for informing staff of the change in routine. When informed by inspector that staff #137 was not aware of any increased cleaning requirements, staff #138 indicated that it was assumed staff #137 was aware. Staff #138 stated that staff #137 will be informed immediately in the change in cleaning expectations related to the outbreak status in the unit. [s. 229. (4)]

3. On September 22, 2014 during the initial tour, Inspector #111 noted identified residents' rooms in McMillan Cottage and Symons units are in isolation with no signage to indicate the type of isolation.

On September 29, 2014, inspector observed unlabeled urinal placed on grab bar next to clean white towels in shared bathroom of an identified room in McMillan unit. PSW #124 and PSW #113 indicated that the urinal is used by Resident #9 at night. PSW #124 indicated that the urinal should not be placed on grab bar. [s. 229. (4)]

4. During the inspection of the home, numerous unlabeled, body contact hygiene items were present in shared use resident areas, which include bedrooms and ensuite washrooms where residents were identified to be on additional precautions for infection prevention and control, for example:
- unwrapped, used rolls of toilet paper on toilet tanks. Some of the rolls were visibly soiled on edges;
-toothbrushes, denture brushes and denture cups (with and without dentures) on unlabeled shelves, including the single shelf that is provided over the sink in many washrooms. In a number of the washrooms, the multiple unlabeled toothbrushes that were present, look the same: white, plastic;
-hairbrushes and combs on unlabeled shelves in washrooms. In a number of shared bedrooms and shared washrooms, the unlabeled hairbrushes that were present, looked the same: white, plastic;
-used soap bars, some in plastic containers, in washrooms
-a used razor in a soiled kidney dish which also contained 4 tooth and denture brushes was present on a shelf over a sink in a washroom
-clean and soiled plastic urinals, bedpans, basins, kidney dishes, urine measures in various locations in ensuite washrooms including on the floor, on toilet tanks, wedged between grab bars and the wall surface. Some of the items were noted to be labeled with room numbers; however, the label did not match the location where the item was provided. In several locations, the items remained on the washroom floor or toilet tank for multiple days.
-in the McMillan Cottage corridor, a plastic caddy provided on a supply cart contained 2 used disposable razors stored in contact with clean supplies including orange sticks, gloves, cups, a hairbrush and denture cleanser.
-in the lower level Craft Kitchen, unlabeled soiled nail clippers and 4 tubes of used lipstick were present in a plastic caddy on a cart. Multiple bottles of nail polish were also present on the cart.

An upholstered chair with a visibly soiled seat is present in tubroom #7, Symons 2. A chair with a split and torn vinyl type upholstered seat is present in a McMillan Garden tub room.

Bath tubs with visibly soiled, dry surfaces were observed in a number of tub rooms. The tubs were available for resident use but were not in a clean and sanitary condition.

A sit to stand lift with visibly soiled hand grips and foot rest surfaces was observed to be available for use on September 25, 26, 29 and October 01, 2014 in the resident

corridor on McMillan Cottage.

The above examples are all present potential cross infection risks to residents. Measures are not in place to prevent the transmission of infections. [s. 229. (4)]

5. The licensee has failed to ensure that information that was gathered on every shift about resident's infections was analyzed daily to detect the presence of infection.

Interviews conducted with RN #131 and RPN #132 identifies that the home's prevailing practice includes gathering information daily related to infections and documenting the information into Point Click Care (PCC) progress notes. Respiratory symptoms were noted in the progress notes in PCC but the information was not analyzed related to Blacklock Cottage unit for the period of September 28 to September 30, 2014.

Review of the line listing for Blacklock Cottage unit related to the outbreak indicated one resident identified as being symptomatic starting September 29, 2014 and five residents being symptomatic on September 30, 2014.
Review of the progress notes for 6 residents in the Blacklock Cottage unit identified as being in outbreak status on October 1, 2014 was completed.
Progress notes for Resident #61 indicated nasal congestion and cough were noted on an identified date.
Progress notes for Resident #63 indicated nasal congestion and cough documented on an identified date.
Both Resident #61 and #63 were documented as having onset of respiratory symptoms and line listed on identified date. [s. 229. (6)]

6. The licensee has failed to ensure that that each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

The home's immunization policy number: I.C.-05-01 indicates "A resident should receive a two-step Tuberculosis Skin Test (TST) on admission, unless the individual has had a documented positive TST"

Interview with ADOC #111 indicated that (Tuberculosis) TB screening is completed for residents within two weeks of admission. The ADOC indicated that TB screening was not completed for new admissions due to broken fridge from February to May 2014.

On June 23, 2014, a registered staff was brought in to do TB screening for everybody that needed to be screened.

Review of health records for Residents #51, #49 and #61 indicated that the residents were not screened for tuberculosis within 14 days of admission.

Residents #51 received a TB skin test step 1 on an identified date about 4 months following admission.
Residents #49 received a TB skin test step 1 on an identified date about 5 months following admission.
Residents #61 received a TB skin test step 1 on an identified date about 3 months following admission.

Review of health records for Residents #54, #46 and #56 admitted during an identified month of 2014 indicated that the residents were not screened for tuberculosis within 14 days of admission. [s. 229. (10) 1.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)The following order(s) have been amended:CO# 006

WN #7: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's rights were fully respected and promoted in a way that fully recognized their individuality and dignity.

Observation of Blacklock (secure unit) indicated all the resident rooms had a padlock on the resident's cupboards that required the use of a key from the staff member to access their personal belongings. Resident #1 and Resident #6 on McMillan Garden also had a padlock on their cupboards.

Interview of PSW indicated the locks are in place to prevent resident from rummaging in other resident's cupboards.

Interview of the Administrator indicated she was not fully aware of the use of the padlocks on resident's cupboards. Interview of ADOC #116 indicated that the padlocks have been in place for years and the home was "weaning them off". The ADOC indicated there was no documented evidence of consent obtained from either the residents or SDM's but only the secure unit had the padlocks in place due to resident's rummaging through cupboards.

Review of the health care records for Resident #12, 13, 14, 15, 16, 17 did not have any documentation showing that the use of the padlocks was done in line of their wishes. Resident #12 did not like going to staff for access to personal clothing. [s. 3. (1) 1.]

2. On September 26, 2014 during a dining observation in the McMillan Cottage dining room, PSW #117 was seated beside Resident #35 providing total feeding assistance. Throughout the lunch meal PSW #117 was observed to be speaking with a family member who was seated at the same table providing assistance to another resident. At no point during the lunch meal did this staff member speak to Resident #35. PSW #117 did not attempt to engage Resident #35 at all throughout the meal. [s. 3. (1) 1.]

3. Resident #5 was interviewed on September 24, 2014 and stated that RPN #112 was not happy when the resident came from outside at an identified time and date. The resident indicated that RPN #112 was bossy and autocratic and told the resident to come earlier at an identified time for the medication because RPN #112 wanted to go home. The resident stated “I did not like the way RPN #112 acted and told RPN #112 that she/he does not know what she/he is doing and what she/he did made me feel angry”.

On a follow up interview with Resident #5 on September 26, 2014, the resident stated "RPN #112 did not yell at me, but she/he was just bossy. She/he was rude to me by the way she/he treated me like I was beneath her/him; that how I felt but I am not". The resident indicated that RPN #112 told the resident that the resident has a curfew. The resident stated not being aware of a curfew but aware that the door closes at an identified time.

RPN #112 documented in a progress note on an identified date that Resident #5 came back at an identified time and the resident was called to treatment room for medications scheduled for 21:00 hrs. The resident was told by RPN #112 that there is a curfew at 22:00 and emphasized that should be followed. The resident was upset and requested a certain dose of medication. Resident #5 told RPN #112 that she/he does not know what she/he is doing and the DOC will be informed. There is no documentation that the DOC was informed of the incident by the resident or RPN #112

During an interview, RPN #112 indicated that the use of the word curfew was not appropriate and meant that the doors are locked at 22:00 hrs. RPN #112 indicated that she/he did not raise her/his voice but was straight to the point. The RPN documented in a progress note on an identified date that Resident #5 keeps holding on to the inhaler chamber even after dose has been given, not letting go. RPN #112 told the resident that the medication dose will not be given if this behavior continues. During an interview, RPN #112 indicated that she/he told the resident that the dose will not be given because the resident was holding her/his hand. The RPN indicated she/he had to be firm with rules and consistent because the resident has an identified medical condition. [s. 3. (1) 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 by ensuring:
- all staff promote and respect residents' rights.
- the rights of Resident #5 and Resident #35 to be recognized and the residents to be treated with respect and dignity, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for Resident #57 that sets out the planned care for the resident related to activity patterns, pursuits including cultural, spiritual and religious preferences and age related needs and preferences.

Resident #57 was admitted to the home on an identified date.
Review of clinical documentation including Resident #57's plan of care and interview with Resident and Family Services Manager indicated that a plan of care related to activity patterns, pursuits including cultural, spiritual and religious preferences and age related needs and preferences has not been developed or documented for Resident #57. [s. 6. (1) (a)]

2. Related to Log # O-000909-14

The licensee has failed to ensure that the plan of care for Resident #3 sets out clear directions to staff and others who provided direct care to the resident.

Review of current plan of care for Resident #3's indicated no focus on oral care or mouth care. The current plan of care under sleep pattern and customary daily routine focus directs staff to brush Resident #3’s teeth at bed time (h.s. care).

Interview with Resident #3's family member indicated that the resident’s teeth are not brushed unless the family member asks for it.

On September 26, 2014, interview with PSW #124 indicated that Resident #3's mouth care is done in the morning after breakfast and the resident requires set up help. Resident #3 reported to inspector brushing own teeth that morning.

On September 29, 2014, interview with Resident #3 with family member present indicated not brushing own teeth for two days.

The plan of care did not include a focus on oral care with clear directions on the frequency of mouth care and the assistance required by Resident #3. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of Resident # 46 so their assessments are integrated , consistent with and compliment each other.

Review of Resident #46 plan of care dated August 15, 2014 indicates the resident is:
- Dependent on staff for activities, cognitive stimulation, social interaction due to: anxiety, impaired mobility.
- Will maintain involvement in cognitive stimulation, social activities as desired through review date.
- Assist/escort to activities of choice that reflect prior interests and desired activity level.
- Invite to scheduled activities
- Thank resident for attendance at activity function.

Review of MDS assessment dated August 15, 2014 for Resident #46, related to psych-social indicates Resident #46 is:

- At ease interacting with others
- At ease doing planned or structured activities
- At ease doing self-initiated activities
- Establishes own goals
- Pursues involvement in life of facility (e.g. makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)
- Accepts invitations into most group activities.

Interview with PSW #114 and PSW #130 indicated Resident #46, has breakfast in bed and remains in bed until lunch time due to discomfort. After lunch the staff will take the resident to the lounge or the resident will return to bed. Resident #46 is not social and does not participate in group activities. The resident likes to be in a quiet environment

Staff interviews and record review for resident #46 indicate no collaboration among staff and others involved in the care of resident #46 in relation to activity patterns and pursuits. [s. 6. (4) (a)]

4. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of Resident #25 so their assessments are integrated, consistent with and compliment each other.

Review of Resident #25's plan of care related to recreation and activities indicates:
Resident #25 is dependent on staff for activities, cognitive stimulation, social interaction
- Is to be assist/escort to activities of choice that reflect prior interests and desired activity level.
- Introduce resident to other residents of similar age, background, interests.
- Invite family members to activity program.
- Invite to scheduled activities.

Review of MDS assessment dated May 26/14 and August 25, 2014 for Resident #25 indicates:
-At ease interacting with others
-At ease doing planned or structured activities
-At ease in group activities.

Interview with PSW #130 and the Resident and Family Services Manager indicated Resident #25:
-does not like to participate in group activities , prefers to be in a quiet setting

preferably in the resident's room.
-resident lies down on the bed after breakfast, as the resident tires easily and wants to rest before family visits in the afternoon.

Staff interviews and record review for resident #25 indicate no collaboration among staff and others involved in the care of resident #25 in relation to activity patterns and pursuits. [s. 6. (4) (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 by ensuring that:
- the plan of care for Resident #3 sets out clear directions to staff and others who provided direct care to the resident related to oral care.
- staff and others involved in the different aspects of care collaborate with each other in the assessment of residents so their assessments are integrated , consistent with and compliment each other related to activity patterns and pursuits of each resident, to be implemented voluntarily.

WN #9: 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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that doors leading to non residential areas are locked when not being supervised by staff, placing residents at potential risk for harm.

-during the inspection on September 25 and 26, 2014 a resident accessible door leading into a storage room that adjoins the main floor auditorium was closed but not locked. The room contains equipment and building control panels. Staff were not present.
-during the inspection on September 29, 2014 between 11:25 and 11:50 am, two doors leading into two serveries from the McPhie dining room, and one door leading from the corridor into a McPhie dining room servery were unlocked and not under supervision by staff. Residents were present in the vicinity of the unlocked doors. The serveries each contained high temperature water dispensing machines, chemical sanitizing agents and one contained a steam table that was hot. [s. 9. (1) 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 by ensuring that doors leading to non residential areas are locked when not being supervised by staff, to be implemented voluntarily.

WN #10: 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 kept clean and sanitary:

- baseboards and the base of an overbed table located in the McMillan Cottage dining room remained visibly soiled during the inspection by Inspector 102 on September 25, 26 and 29, 2014;
- a number of usable bath tubs were observed to have soiling evident on dry interior surfaces: Millenium tub in Symons tub room #7, bath tub in Blacklock Cottage; bath tub in McMillan Cottage tub room #4
- in Symons 2, tub room #8 debris and miscellaneous items (razor, spray bottle, brush) have accumulated on the floor surface between the faucet end of the tub and an adjacent wall surface;
- On September 25 and 26, 2014 surfaces of hand grips and foot rests were visibly soiled on a sit stand lift present in the corridor in McMillan Cottage;
- peeling and soiled duct tape was present on the floor surface in McMillan Cottage in an identified resident's room, in the McMillan Garden corridor between a set of corridor separation doors, at the entrance to McMillan Cottage tub room #3;
- On September 25, 2014 dust build up was evident on a number of lower bed frames in McMillan Cottage bedrooms. [s. 15. (2) (a)]

2. Resident #23 was observed by Inspector #541 on September 22, 2014 to be sitting in wheelchair with a seat belt applied. Resident's seat belt was visibly soiled and this was observed each day of inspection until September 30, 2014 which it appeared clean. [s. 15. (2) (a)]

3. 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:

- gaps are evident in floor coverings in the main floor corridor in the vicinity of the Administrator, Director of Care and Assistant Director of Care offices; lower floor corridor in 3 areas in the vicinity of the two kitchen storage rooms; in identified rooms and in the resident washroom across from identified residents' rooms in McMillan Garden; Symons identified residents' rooms; Symons corridor' near identified residents' rooms.
- floor surfaces are damaged and/or not level between the McMillan Cottage corridor separation doors near the mail room; at the washroom doorway in an identified resident's room; at the entrance to McMillan Cottage tub room #3; McMillan Garden corridor between separation doors near an identified room.

Non intact, uneven floor surfaces are a potential risk to the health, safety and well being of residents. Gaps in flooring present cleaning challenges for staff as debris and moisture may collect; uneven floor surfaces present mobility challenges to residents and may increase the risk for falls. [s. 15. (2) (c)]

4. - Individually switched exhaust fans were identified to be non functional in a number of areas: washrooms that adjoin identified residents' rooms, McMillan Cottage tub room #3, McMillan Garden identified residents' rooms ensuite washroom;
- on September 25 and 29, 2014 five light fixtures were observed to be nonfunctional in the McMillan Cottage dining room. [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 by ensuring that:
- the home, furnishings and equipment are kept clean and sanitary,
- the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that O. Reg. 79/10, s.30(1).3 is complied with in respect to organized programs of recreational and social activities required under sections 10 of the Act.

Interview with the Resident and Family Services Manager indicated that Activity Program has not been updated or evaluated annually. [s. 30. (1) 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 by ensuring that the home's organized program of recreational and social activities is evaluated and updated at least annually, to be implemented voluntarily.

WN #12: 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 comply with O.Reg 79/10, s.68(2)(e)(ii), whereby the licensee did not ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record each resident's height annually.

It was confirmed by ADOC #111 that resident weights and heights are documented within the resident's electronic health care records. Of the ten resident health care records reviewed, all ten records were found to lack an annual recorded height measurement.

Inspector #541 spoke with the ADOC #111 who acknowledged that the home measures heights upon admission, however, could not confirm if the home measures heights annually thereafter. [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 by ensuring that each resident's height is measured annually, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the meal service is provided in a congregate dining setting unless a resident's assessed needs indicate otherwise.

On September 22, 25, 26 and 29, 2014 Resident #48 was observed to be sitting outside the dining room on McMillan Cottage unit. The RPN staff member described this area as a hallway that is a busy thoroughfare.

On September 30, 2014 inspector #541 spoke with Resident #48 who stated preference to eat in the dining room however stated being "kicked out". Resident's family member was present and this information was confirmed. Resident's family member indicated this concern has been brought forward with the home however Resident #48 continues to eat in the hallway outside the dining room.

Resident #20, 40, 46 and 49 were also observed to be eating outside the dining room on their respective home areas on September 29, 2014.

A PSW and RPN staff members were unable to identify the residents' assessed need to indicate that they cannot eat in a congregate dining setting.

On September 30, 2014 inspector #541 spoke with the ADOC #111 who stated that any assessment to indicate that a residents cannot eat in the congregate dining room would be found in the residents' plan of care.

Inspector #541 reviewed the plans of care for Residents #20, 40, 46, 48 and 49. There is no evidence of any assessment to indicate that the residents identified above cannot eat in the congregate dining room. [s. 73. (1) 3.]

2. The licensee has failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On September 25, 2014 a dining observation was completed in the McMillan Cottage dining room. Resident #45 was provided with soup at approximately 12:54 hrs which remained untouched and at 13:00 hrs resident was provided with entree. Resident was encouraged by staff member to eat soup, which was left in front of the resident while the entree was left to the side.

On September 26, 2014 a dining observation was completed again in the McMillan Cottage dining room. Resident #45 was provided with soup at approximately 12:40 hrs. At 12:48 hrs resident was served with entree which was left untouched while the resident began to eat soup. Resident #38 was served soup at approximately 12:35 hrs and at 12:43 hrs resident's entree was served while soup was left in front of the resident. Resident #36 was provided with entree at 12:45 hrs while the soup remained in front of the resident.

Resident #36 and Resident #38 both require extensive to total assistance to eat according to their most recent plans of care. This assistance was not provided prior to the entree being served. [s. 73. (1) 8.]

3. The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.

Resident #38's current plan of care indicates high nutritional risk related to inadequate intake and progressive weight loss. Resident #38's plan of care also indicates the resident requires constant encouragement and physical assistance and to remain with resident during meals most of the time.

Resident #39's current plan of care indicates a moderate nutritional risk related to erratic intake, difficulty chewing regular texture foods and difficulty swallowing regular consistency fluids. Resident #39's plan of care also indicates the resident requires total assistance for most meals.

On September 25, 2014 a dining observation was completed in the McMillan Cottage dining room. Residents #38 and #39 who sit at the same table were served their soup at 12:44 hrs with no staff was available to assist them. At 12:48 hrs a PSW staff member sat down beside Resident #39 to provide feeding assistance. At 12:56 hrs Residents #38 and #39 were provided with their entree and no assistance was provided until 13:00 hrs at which time Resident #39 was assisted by PSW #104. Between 13:00 -13:09 hrs PSW #104 was observed to leave Resident #39 a minimum 4 times while assisting to feed the resident. Resident #38 was not provided feeding assistance until 13:31 hrs when RPN staff member sat down beside the resident. At this time resident's meal was sitting in front of the resident for 30 minutes, Resident #38's meal was not re-heated prior to being fed to the resident. At 13:30 hrs Resident #39 was provided with dessert but was not offered assistance to eat it until 13:57 hrs.

It was noted at 13:23 hrs that PSW #104 documented the food and fluid intake for Resident #38 and #39 when neither resident had been offered full assistance to finish their meal.

On September 26, 2014 at 12:35 hrs Resident #38 was observed with soup in front of the resident. A PSW staff member was sitting at Resident #38's table providing assistance to Resident #39. PSW staff member made no attempt to assist Resident #38. At 12:43 hrs Resident #38 was provided with main entree while the soup remained in front of the resident untouched. No physical assistance was provided to eat until 12:45 hrs at which time the soup was fed to the resident.

Resident #36 was provided with entree at 12:45 hrs. Resident #36's current plan of care indicates the resident requires extensive to total assistance with meals. Resident #36 was not provided with assistance until 13:08 hrs at which time the resident had fallen asleep. Resident #36 did not eat anything and was removed from the dining room. As per Resident #36's health care record, the resident has a medical condition that is managed by oral medication and diet.

On September 29, 2014 at 14:00 hrs Inspector #166 observed Resident #46 sitting in the common area with an over-bed table in front of the resident from the lunch meal. Resident had nutritional supplements that remained untouched on the over bed table.

Resident #46's current care plan indicates a high nutritional risk, requires constant encouragement and staff are to remain with resident during meals. No staff were with resident at the time of observation. [s. 73. (2) (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 by ensuring:
- meal service is provided in a congregate dining setting unless a resident's assessed needs indicate otherwise,
- meals are served course by course for each resident unless otherwise indicated by the resident or the resident's assessed needs,
- no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

Unlocked treatment caddies containing prescription creams were observed throughout the RQI as follows:

On September 25, 2014 at 11:40 hrs in the McMillan Garden Unit, inspectors #102 and #570 observed a treatment caddie containing prescription creams in the linen cart in the resident hallway, easily accessible to residents.

On September 26, 2014 in the McMillan Garden Unit, inspector #102 observed prescription creams remained accessible in the plastic caddie on the supply cart parked in the corridor by an identified room.

On September 29, 2014 at 15:03 hrs in the Symons Unit, inspector #194 observed a treatment caddie containing prescription creams such as, Hydrocortisone, Ectosone, Anusol and Clinadmaycin Tretinoin, stored in the linen cart, in the resident hallway.

On September 29, 2014 at 15:10 hrs in the Blacklock House Unit inspector #194 observed a treatment caddie containing prescription creams such as , Hydrocotisone and Ectosone stored in the linen cart.

On September 30, 2014 at 09:30 hrs in the Symons Unit, inspector #194 observed a treatment caddie containing prescription creams such as, Hydrocortisone, Ectosone, Anusol and Clinadmaycin Tretinoin stored in the linen cart, in the resident hallway.

On September 30, 2014 at 09:11 hrs in the McMillan Garden Unit, inspector #570 observed Resident #5's identified medications on the dining room table, unattended. Two residents were left in the dining room sitting at their tables, with one resident wandering in/out of the dining room. At 09:20 hrs RPN #121 was located by inspector #194 and stated that the inhalers had been left with the resident in the dining room so that the resident could take the inhalers, stating that the routine practice with this resident is that the resident would notify RPN when finished and RPN would collect the inhalers.

On October 1, 2014 at 16:00 inspector #166 found a medication cart left unattended and unlocked by RPN #142 in the corridor of Symons Unit where residents were observed walking by. [s. 130. 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 by ensuring that all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

Two easily accessible grab bars are not provided in the shower located in the McMillan Garden bathing room. A grab bar is located on the faucet wall. A grab bar is not provided as required on an adjacent wall in the shower. [s. 14.]

2. Several other showers were also identified that were not equipped with a grab bar on the wall surface that is adjacent to the faucet wall; for example: tub room #7 and tub room #8 on Symons 2; tub room in Blacklock Cottage. [s. 14.]

3. Shower in tub room #4 in McMillan Cottage is not equipped with 2 grab bars. [s. 14.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. Related to Log # O-000909-14

The licensee has failed to ensure that Resident #3 received fingernail care, including the cutting of fingernails.

A progress note on an identified date by RPN #141 indicated that Resident #3 trimmed own nails and cut too deep.

Progress note on an identified date indicated that Resident #3's family member requested nails be trimmed by PSW this evening. Resident agreed to have nails trimmed.
There is no documentation that resident's nails were trimmed.

On September 25, 2014, Resident #3 was observed to have long fingernails. The resident liked to have nails cut short.

On September 26, 2014, Resident #3 was observed with no change to the resident's nails length following a bath on September 25, 2014.

On September 29, 2014, Resident #3 indicated to inspector, while family member was present, preference to have nails cut short. Resident #3's family member indicated that Resident #3's fingernails should be cut short as the resident has poor hand hygiene and goes to bathroom frequently.

On September 29, 2014 interview with RPN #125 indicated that Resident #3's nails are cut once or twice on bath days. The resident usually refuses to have nails done.

Review of documentation in regards to bathing for Resident #3 for the month of September 2014 indicated finger nail care was done for Resident #3 on September 4, 11, 25, 2014 and the resident refused on September 7, 18, 21, 2014. [s. 35. (2)]

WN #17: 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 has failed to ensure that written response is provided within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Interview of the Residents' Council President indicated that any concerns identified at the meeting are discussed at the meetings but not aware of any written responses.

Review of the Residents' Council Meeting minutes from September 20, 2013 to September 19, 2014 indicated the following concerns with no written response provided:
-Minutes from September 20, 2013 had concerns on Symons unit regarding: air conditioning running in a resident's room, fan running outside of a resident's room, and hot/cold temperatures in the dining room.
-Minutes from October 18, 2013 indicated issues with fans/air conditions and dirty dishes not being picked up around the Symons unit.
-Minutes from December 20, 2013 indicated concerns re: activity calendars not indicating where the program was located, Residents' Council meeting minutes to be posted on all home units, housekeeping not putting residents items back where they were after being cleaned.
-Minutes from January 17, 2014 indicated several television remote controls missing.
-Minutes from May 16, 2014 indicated a concern that condiments not always on the tables at mealtimes.
-Minutes from September 19, 2014 indicated concerns of print too small on activity calendar and it is in a location the residents cannot get close to.

Interview of the Administrator indicated a response is not provided in writing within 10 days to concerns but concerns are brought forward to the manager responsible and action taken. [s. 57. (2)]

WN #18: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that when Family Council concerns are received the licensee responds in writing within 10 days.

Interview with the Family Council Secretary indicated the Family Council does not receive a written response to concerns brought forward. All concerns directed to the licensee by the Family Council have been addressed verbally.

Interview with the Administrator confirmed that concerns brought forward by the Family Council are responded to verbally. [s. 60. (2)]

WN #19: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the satisfaction survey in order to seek the advice of the Family Council about the survey has been made available to the Council.

Interview with the Administrator and the Secretary of the Family Council indicated the results of the satisfaction survey have not been made available to Family Council. [s. 85. (4) (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of the restraining of resident by use of a physical device is undertaken on a monthly basis.

During an interview, RN #106 stated that no monthly analysis of restraints were being completed in the home.

During an interview, ADOC #111 stated that at this time the home was not completing a monthly analysis of the restraints in the home. [s. 113. (a)]

2. The licensee has failed to ensure that an annual evaluation is conducted to determine the effectiveness of the restraint policy.

Review of the "Restraint Policy" was completed, it was dated December 2011

During an interview, ADOC #111 stated that an annual evaluation of the Restraint policy had not been completed. [s. 113. (b)]

Issued on this 7 day of August 2015 (A2)

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Ottawa Service Area Office
347 Preston St, Suite 420
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SAMI JAROUR (570) - (A2)

Inspection No. / No de l'inspection : 2014_327570_0018 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-000925-14 (A2)

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

Report Date(s) / Date(s) du Rapport : Aug 07, 2015;(A2)

Licensee / Titulaire de permis :
THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND
983 Burnham Street, COBOURG, ON, K9A-5J6

LTC Home / Foyer de SLD :
GOLDEN PLOUGH LODGE
983 BURNHAM STREET, COBOURG, ON, K9A-5J6

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 : CLARE BRIGGS (ACTING)

To THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND, 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. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee will ensure that every resident accessible window in the home that opens to the outdoors cannot be opened more than 15 cms.

Grounds / Motifs :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimeters (cm).

During the inspection commencing on September 22, 2014, many resident accessible windows were identified that opened to a width greater than 15 cm.:
-14 bedroom windows were identified in McMillan Garden that open to a width of approximately 30 cm
- several windows in McMillan Cottage TV Lounge, tubroom #3 and the lounge by room 314 open more than 15 cm
-8 windows in the auditorium and 4 windows in the chapel have openable areas between approximately 24 and 29 cm

Critical Incident Report (CIR) was received and identified that on an identified date a resident was found outside of the LTC home. The CIR report states that " the security guard found a window in an identified lounge that had been opened quite wide (the restrictor had broken) and the screen had been pushed out and was lying on the ground." It was further identified in the CIR that the following actions were taken to prevent recurrence of missing resident: 'The window restrictors were replaced in all lounge windows and all other resident accessible windows are being checked to ensure the restrictors are in good working order."

Resident accessible windows that do not have openable areas restricted to a maximum of 15 cm present 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 :

Nov 07, 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. 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee will ensure that the resident staff communication and response system is:
- available in every area accessible to residents, including the residents' laundry room on the lower level;
- available at each tub and shower used by residents;
- clearly indicates where an activated signal is coming from which includes ensuring that the visual identification on the provided audio visual enunciators corresponds to the location of the point of activation
- properly calibrated so that the level of sound is audible to staff to ensure a prompt response to the point of activation.

Grounds / Motifs :

1. The resident staff communication and response system is not available at a number of bath and shower locations used by residents:
-McMillan Cottage tub rooms #3, #4
-McMillan Garden tub room # 2
Note: all tub rooms were not checked.

The lack of availability of the resident staff communication and response system at baths and showers is a potential safety risk to residents. (102)

2. The resident staff communication and response system is not available in every area accessible by residents. It was noted that the lower floor residents' laundry room is not equipped with resident staff communication and response system. (102)

3. The resident staff communication and response system does not clearly indicate when activated where the signal is coming from:
- in the McMillan Cottage resident home area, room numbers located next to each bedroom door do not correspond to the visual display on the call system panel located within the nursing station; for example: a signal activated from an identified resident's room identifies as a different resident's room on the panel.
- in the McMillan Cottage resident home area, a signal activated from the dining room is indicated only within the nursing station. The signal is not audible or visible to staff outside of the nursing station.
-the resident staff communication and response system provided in resident accessible communal areas and washrooms located in the vicinity of the main entrance closest to Burnham street alert only on an audio visual enunciator located within the Blacklock Cottage secure resident home area.
-the resident staff communication and response system provided within the Blacklock Cottage secure resident home area visually displays activated signals from bedrooms, washrooms, and the tubroom on corridor dome lights within the wing. The audio visual enunciator panel for the home area is located in the Symons 2 home area on an upper floor of the home.

The resident staff communication and response system is to clearly indicate where activated signals are coming from to facilitate a prompt staff response to calls for assistance from residents, staff and visitors. (102)

4. The resident staff communication and response system provided in Golden Plough Lodge is an audio visual system that primarily uses sound to alert staff when a call has been activated on the system.

During the inspection on September 25, 26 and October 01, 2014, the resident staff communication and response system was not audible to staff in the corridor in the McMillan Cottage resident home area in the vicinity of the lounge and identified residents' rooms. The dining room signal is not audible to staff, other than in the immediate vicinity of the nursing station.

In Blacklock Cottage, the system provided in the majority of resident areas, including bedrooms, washrooms, is not audible to staff within the resident home area. A call that is activated on the system, illuminates a dome light that is located in the corridor outside of the calling location. The call also activates on an audio visual enunciator panel that is located at a nursing station on an upper floor of the home, in the Symons 2 resident home area. Nursing staff identified that staff from Symons 2 "will call down, if bell not answered in a timely manner".

During the inspection on September 30, 2014 it was identified that an operational audio visual enunciator for the resident staff communication and response system is provided within the Blacklock Cottage nursing station for the games room that is located within the home area and for the resident accessible communal areas which are located outside this home area, on the main floor near the Burnham Street entrance and auditorium. Activated calls for these communal areas are audible to staff only within Blacklock Cottage.

The resident staff communication and response system is not properly calibrated so that the level of sound is audible to staff.

The resident staff communication and response system is an essential safety system to support the health, comfort, safety and well being of residents. Lack of function, availability or accessibility of the system is a potential risk to residents. (102)

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

Jan 31, 2015

Order # / Ordre no : 003 **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 :

(A2)
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 throughout corridors;
- A minimum level of 215.28 lux in residents' ensuite washrooms and communal areas;
- A minimum level of 322.92 lux of continuous consistent lighting throughout stairways.

The licensee will provide a written progress report indicate the status of the lighting levels by February 28, 2016. This progress report must be submitted in writing to the MOHLTC, Attention: Sami Jarour, Fax (613)569-9670.

Grounds / Motifs :

1. On September 25, 26 and 30, 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 and warmed up.

Levels of illumination throughout the majority of residents' ensuite washrooms were less than 50% to 75% of the required lighting level of 215.28 lux.(Blacklock House ensuite washrooms excluded);

Levels of illumination throughout a number of program, lounge and dining areas were less than 50% to 75% of the required lighting level of 215.28 lux including: Blacklock Cottage dining room; McMillan Cottage dining room; TV lounge in McMillan Cottage; Symons Cottage lounge.

The levels of illumination provided in some areas in the Symons and McMillan upper and lower floor corridors were identified to range from less than 50% to 75% of the required illumination level of 215.28 lux of continuous, consistent lighting; for example: Symons 2 corridor in the vicinity of the nursing station near identified residents' rooms; McMillan Garden corridor in the vicinity of identified residents' rooms and near the entrance to the dining room; McMillan Cottage corridor section that extends from the hair salon and tub room #3 through to the dining room and nearby separation doors.

A minimum illumination level of 322.92 lux of continuous, consistent lighting is not provided throughout the 2 stairways on the east side of the building that run between the McMillan and Symons home areas. The illumination level ranged from less than 50% to 75% of the requirement.

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 :

Jul 31, 2016(A2)

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer’s instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer’s instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee will ensure that
- All seat belt restraints are applied safely and in accordance with Physiotherapist's directions (in absence of Manufactures instructions) in the home immediately upon receipt of this report;
- Education to be provided to Registered staff and Personal Support Workers in application and conducting safety checks of seat belt restraints;
- An analysis of the restraints will be completed monthly;
- An evaluation of the restraint program is to be completed annually.

Grounds / Motifs :

1. On September 23, 2014 Resident #17 was observed by inspector to be sitting in the wheelchair with a seat belt in place. The seat belt was found to be fastened, loosely lying in the resident's lap. RPN #100 stated that Resident #17 is pulling on the seat belt causing it to loosen.

Physiotherapist (PT) stated that when applying a seat belt, all staff should allow for approximately one inch space between the resident's body and the seat belt.

ADOC #111 stated the home had no manufactures instructions for restraints and that the PT was providing directions for restraint applications.

On September 23, 2014 PT assessed the seat belt for Resident #17 and found it to be loose, giving direction to staff that the seat belt was to be removed, until vendor could fix the belt to prevent it from sliding.

On September 25, 2014 the seat belt for Resident #17 had been fixed by vendor and was no longer able to be pulled causing it to be loose.

Review of Resident #17’s current plan of care identifies the following for restraints: Use of an external device for prevention of injury to self characterized by high risk for injury due to falls, impaired mobility, device used is (seat belt).

Registered staff interviewed stated that Resident #17 would attempt to stand, the seat belt not being properly fastened places the resident at high risk for falls and potential for harm related to strangulation.

On September 29, 2014 Resident #39 was observed by inspector #194 to be sitting in the wheelchair with a seat belt in place. The seat belt was found to be fastened, loosely lying in the resident's lap. RN #108 and RPN #102 stated that the seat belt for Resident #39 was not applied properly. PSW #118 and #119 stated that Resident #39 is pulling on the seat belt causing it to loosen. PSW #118 was able to re loop the seat belt to include the safety clip, which had not been in place at time of observation. The seat belt is now fastened in a manner that the resident cannot loosen.

On September 30, 2014 at 09:40 hrs Resident #39 was observed by inspector #194 to be sitting in the breeze way, in the wheelchair with a seat belt in place. The seat

belt was found to have a four inch gap between the belt and the resident's abdomen.

On September 30, 2014 at 09:50 hrs PT was located and seat belt was assessed. PT stated that the seat belt was too loose on the resident and proceeded to tighten the belt. PT stated that education has been provided to staff on how to check to ensure that seat belts are properly fastened.

On September 30, 2014 at 10:00 hrs PSW #122 who stated that when assisting Resident #39 with care needs today, a safety check was completed for the resident's seat belt and that the belt was properly fastened.

Review of Resident #'39's current plan of care identifies the following for restraints: Use of an external device for prevention of injury to self or to others characterized by high risk for injury/falls; device used is lap belt in Broda chair; needs seat belt related to loss of balance and identified medical condition.

PSW staff interviewed stated that Resident #39 would attempt to stand, the seat belt not being properly fastened places the resident at high risk for falls and potential for harm related to strangulation.

Furthermore, as per WN #20 of the inspection report, the licensee failed to ensure that:
- an analysis of the restraining of resident by use of a physical device is undertaken on a monthly basis.
- an annual evaluation is conducted to determine the effectiveness of the restraint policy.

During an interview, RN #106 stated that no monthly analysis of restraints were being completed in the home.

During an interview, ADOC #111 stated that at this time the home was not completing monthly analysis of the restraints in the home and that the annual evaluation of the program had not been completed. (194)

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

Jan 31, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will ensure that the home is a safe environment for its residents:
-commercial high temperature hot water dispensing equipment is to be secured to prevent unsupervised resident use and unsupervised resident access to the equipment.

Grounds / Motifs :

1. High temperature hot water dispensing equipment is accessible to residents on a non- secure, former servery counter top, adjacent to the kitchen on the lower level of the home. During the inspection on September 26, 2014 the temperature of hot water dispensed into a cup from the "Bunn" counter top dispensing unit was 73 degrees Celsius.

The licensee has not ensured that the home is a safe environment for its residents. Access to the hot water dispensing equipment is a potential safety risk to residents. (102)

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

Nov 07, 2014

Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will prepare, submit and implement a plan to ensure that all staff participate in the implementation of the infection prevention and control program

The plan will ensure:
- measures to be implemented to minimize the risk of cross contamination and to prevent the transmission of infections;
- daily analysis of residents’ symptoms to detect the presence of infection is completed in all units;
- re-education of all staff related to infection control practices in the home;
- screening for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available;
- annual evaluation of the program to be completed.

The licensee will provide a written plan by November 15, 2014.
This plan must be submitted in writing to the MOHLTC, Attention: Sami Jarour, Fax (613) 569-9670.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On September 22, 2014 during the initial tour, Inspector #111 noted identified residents' rooms in McMillan Cottage and Symons units are in isolation with no signage to indicate the type of isolation.

PSW #118 was interviewed and stated carrying in own uniform, a nail clipper for resident use. The PSW stated that the nail clipper is disinfected by using the hand sanitizer solution of alcohol wipes.

Observed in an identified resident's room (shared bathroom, with a resident identified with a medical condition) an oxygen Concentrator with nasal prong tubing was noted in the bathroom in close proximity to a commode chair.

During a medication administration, RPN #107 was noted to not complete hand hygiene prior to or after administration of insulin and oral medications.

On September 29, 2014, Inspector observed unlabeled urinal placed on grab bar next to clean white towels in shared bathroom of in an identified room in McMillan unit. PSW #124 and PSW #113 indicated that the urinal is used by Resident #9 at night. PSW #124 indicated that the urinal should not be placed on grab bar.

During the inspection of the home, numerous unlabeled, body contact hygiene items were present in shared use resident areas, which include bedrooms and ensuite washrooms where residents were identified to be on additional precautions for infection prevention and control, for example:
- unwrapped, used rolls of toilet paper on toilet tanks. Some of the rolls were visibly soiled on edges;
-toothbrushes, denture brushes and denture cups (with and without dentures) on unlabeled shelves, including the single shelf that is provided over the sink in many washrooms. In a number of the washrooms, the multiple unlabeled toothbrushes that were present, look the same: white, plastic;
-hairbrushes and combs on unlabeled shelves in washrooms. In a number of shared bedrooms and shared washrooms, the unlabeled hairbrushes that were present, looked the same: white, plastic;
-used soap bars, some in plastic containers, in washrooms
-a used razor in a soiled kidney dish which also contained 4 tooth and denture brushes was present on a shelf over a sink in a washroom
-clean and soiled plastic urinals, bedpans, basins, kidney dishes, urine measures in various
locations in ensuite washrooms including on the floor, on toilet tanks, wedged between grab bars
and the wall surface. Some of the items were noted to be labeled with room numbers; however, the label did not match the location where the item was provided. In several locations, the items
remained on the washroom floor or toilet tank for multiple days.
-in the McMillan Cottage corridor, a plastic caddy provided on a supply cart contained 2 used
disposable razors stored in contact with clean supplies including orange sticks, gloves, cups, a
hairbrush and denture cleanser.
-in the lower level Craft Kitchen, unlabeled soiled nail clippers and 4 tubes of used lipstick were
present in a plastic caddy on a cart. Multiple bottles of nail polish were also present

on the cart.

An upholstered chair with a visibly soiled seat is present in tubroom #7, Symons 2. A chair with a split and torn vinyl type upholstered seat is present in a McMillan Garden tub room.
Bath tubs with visibly soiled, dry surfaces were observed in a number of tub rooms. The tubs were available for resident use but were not in a clean and sanitary condition.
A sit to stand lift with visibly soiled hand grips and foot rest surfaces was observed to be available for use on September 25, 26, 29 and October 01, 2014 in the resident corridor on McMillan Cottage.

The above examples are all present potential cross infection risks to residents. Measures are not in place to prevent the transmission of infections. (102)

Staff #137 stated to inspector #194 that she/he was informed of outbreak declared on October 1, 2014 by RPN when arrived on the Blacklock Cottage unit. Staff #137 stated “its not a serious one" and being aware of one resident affected "pointing up the hall". Staff #137 indicated that there was no increased cleaning requirements related to the outbreak status in the unit and was not told to increase cleaning at this time.

Interview with Environmental Service Clerk #138 was conducted on October 2, 2014 indicated the home had a policy related to cleaning requirements in an outbreak situation and the Environmental Service Manager and herself are responsible for informing staff of the change in routine. When informed by inspector that staff #137 was not aware of any increased cleaning requirements, staff #138 indicated it was assumed staff #137 was aware. Staff #138 stated that staff #137 will be informed immediately in the change in cleaning expectations related to the outbreak status in the unit.

Interviews conducted with RN #131 and RPN #132 identifies that the home's prevailing practice includes gathering information daily related to infections and documenting the information into Point Click Care (PCC) progress notes. Respiratory symptoms were noted in the progress notes in PCC but the information was not analyzed related to Blacklock Cottage unit for the period of September 28 to September 30, 2014.

Review of the line listing for Blacklock Cottage unit related to the outbreak indicated one resident identified as being symptomatic starting September 29, 2014 and five residents being symptomatic on September 30, 2014.
Review of the progress notes for 6 residents in the Blacklock Cottage unit identified as being in outbreak status on October 1, 2014 was completed.
Progress notes for Resident #61 indicated nasal congestion and cough were noted on an identified date.
Progress notes for Resident #63 indicated nasal congestion and cough documented on an identified date.
Both Resident #61 and #63 were documented as having onset of respiratory symptoms and line
listed on an identified date.

The home's immunization policy number: I.C.-05-01 indicates "A resident should receive a two-step Tuberculosis Skin Test (TST) on admission, unless the individual has had a documented positive TST"

Interview with ADOC #111 indicated that (Tuberculosis) TB screening is completed for residents within two weeks of admission. The ADOC indicated that TB screening was not completed for new admissions due to broken fridge from February to May 2014. On June 23, 2014, a registered staff was brought in to do TB screening for everybody that needed to be screened.

Review of health records for Residents #51, #49 and #61 indicated that the residents were not
screened for tuberculosis within 14 days of admission.

Residents #51 received a TB skin test step 1 on an identified date about 4 months following admission.
Residents #49 received a TB skin test step 1 on an identified date about 5 months following admission.
Residents #61 received a TB skin test step 1 on an identified date about 3 months following admission.

Review of health records for Residents #54, #46 and #56 admitted during an identified month of 2014 indicated that the residents were not screened for tuberculosis within 14 days of admission. (570)

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

Feb 28, 2015(A1)

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

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

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

Issued on this 7 day of August 2015 (A2)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : SAMI JAROUR - (A2)

Service Area Office / Bureau régional de services : Ottawa