Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 6, 2015	2015_228172_0006	L-001727-15	Resident Quality Inspection

Licensee/Titulaire de permis

GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

GOLDEN YEARS NURSING HOME
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

JOAN WOODLEY (172), BERNADETTE SUSNIK (120), BONNIE MACDONALD (135), DEBORA SAVILLE (192), TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 20, 21, 22, 23, 27 and 28, 2015

A critical incident was inspected concurrently with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the interim Executive Director, the interim Director of Care, the Vice President of Care and Services for peopleCare, the Program Manager, the Office Manager, the Food Service Manager/Laundry/Housekeeping, the Registered Dietitian, the RAI-Coordinator, 2 Registered Nurses (RN's), 6 Registered Practical Nurses (RPN's), 12 Personal Support Workers (PSW's), Resident Council Chair, Residents and Family members. The Inspectors toured the home, observed meal services, medication pass and care provided to residents, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, minutes related to the inspection and observed the general maintenance, cleaning and condition of the home.

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
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and is therefore subject to lighting requirements under the section of the lighting table titled "All Other Homes".

Lighting levels were measured in tub rooms, common spaces, dining areas, resident bedrooms, ensuite bathrooms and corridors. Outdoor conditions were bright and natural daylight was excluded as much as possible by pulling window covers. All light fixtures were turned on if not already illuminated and allowed to warm up. Using a hand held lighting meter, held 30 inches above and parallel to the floor, readings were taken which provided inadequate illumination.

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. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature of the home was maintained at a minimum of 22 degrees Celcius (C).

Residents reported feeling cold in various sections of the home between January 20, 2015 and January 27, 2015. Outdoor air temperatures were between -15C and -5C during this time period. On January 27, 2015, between 10 and 11:45 a.m., indoor air temperatures were taken in rooms by placing a digital thermometer on furniture as close to the centre of the room as possible and away from windows and forced air heating grills. Windows were noted to be closed in all cases and in some instances, plastic was observed to be over the windows. The thermometer was left in each room 15-25 minutes. The readings were below 22'C.

On January 28, 2015, indoor air temperatures were taken at 9:30 a.m. in 3 rooms. The temperatures were below 22'C.

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place are complied with.

The home's Skin and Wound Care Management Program policy dated October 1, 2014,

indicated that Registered staff would complete a Head to Toe Skin Assessment Form upon admission, quarterly, annual and change in status assessments.

A review of a specific resident's clinical health record indicated that an annual assessment, a significant change assessment and a quarterly assessment were all completed in 2014, however, a Head to Toe Skin Assessment was not completed on all three occasions.

The Interim Executive Director confirmed that Head to Toe Skin Assessments should have been completed on the resident's annual, significant change and quarterly assessments and that this is the home's expectation. [s. 8. (1) (a),s. 8. (1) (b)]

2. The home's Skin and Wound Care Management Program policy dated October 1, 2014, indicated that Registered staff would complete a Head to Toe Skin Assessment Form upon admission, quarterly, annual and change in status assessments and ensure a nutrition referral was sent to the Registered Dietitian for altered skin integrity.

A review of another resident's clinical health record indicated that 2 quarterly assessment were completed for this resident, however, a Head to Toe Skin Assessment was not completed on both occasions when reviewed during this inspection.

Chart review revealed a member of the registered staff identified an area of altered skin on a resident.

A review of this resident's clinical health record and interview with the home's skin and wound nurse confirmed that there was no nutrition referral sent to the Registered Dietitian for the area of altered skin.

Interview with the Interim Executive Director revealed it is the home's expectation that a nutritional referral would be sent to the Registered Dietitian when there is altered skin integrity. [s. 8. (1) (a),s. 8. (1) (b)]

3. Policy review of Self-Administration of Medications, dated January 2014 indicated that the presciber is to write the medication order including the directions "may self-administer", the medication is to be documented on the eMAR with a note "for self administration"; the resident is counseled on the use and self administration of the medication and a note is to be made in the medical record; the resident is to sign a "Resident Self Administration of Medication Agreement; a "Self-Administration

Assessment Form is to be completed quarterly with any change in the resident's status; the plan of care is to include that the resident is capable of self-administration; the nurse is to document in the progress notes weekly that monitoring has been done and the extent to which the resident is compliant with self-administration.

A specific resident was prescribed a medication and the physician noted that the resident may self administer.

A review of the quarterly medication review failed to identify a current order for the self administration of this medication. The resident was observed with the medication in his/her possession.

Interview with a member of the registered staff confirmed that the resident does have this medication in his/her possession.

Record review and interview with a member of the registered staff confirmed that self administration was not identified on the Physician Order, Medication Administration Record (MAR), was not included in the plan of care, that the resident had not signed a "Resident Self-Administration Agreement" and quarterly assessments of the resident Self-Administration had not been recorded. The Progress Notes were reviewed and a member of the registered staff confirmed that weekly evaluation of the resident's self administration had not been completed.

Interview with this resident confirmed that he/she continues to have the medication in his/her possession.

Interview with the Interim Executive Director revealed it is the home's expectation that staff will follow all the steps in the self-administration policy for those residents who are allowed to do so. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home were equipped with an audible door alarm.

Observations of the main entrance door leading to a foyer and to the outdoors was tested by holding it open. After 20 seconds, it was confirmed that it set off a sound at the nurse's station which signified the connection to the resident-staff communication and response system, but not an audible door alarm at the door.

This test was repeated with a door leading to a stairwell. It was not equipped with a door alarm either.

Interview with the Interim Executive Director confirmed the above and shared it is the home's expectation that all doors leading to stairways and the outside are to be equipped with audible door alarms. [s. 9. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all doors leading to stairways and to the outside of the home are equipped with an audible door alarm, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Through interviews and observations certain call bells were found to be non-functioning.

Observations also revealed resident accessible areas within the home did not have activation stations should a resident need to call staff for assistance.

Interview with the Interim Executive Director confirmed there is no resident-staff communication and response system in the identified locations and it is the home's expectation that the home be equipped with a resident-staff communication and response system that is available in every area accessible by residents. (120) (135) [s. 17. (1) (d)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an allegation of abuse was immediately reported to the Director.

A Critical Incident Report was not filed immediately for an alleged incident of verbal and physical abuse toward a resident by staff.

Review of the home's records related to the investigation of the incident confirmed that the Director was not immediately notified of the allegation of abuse. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an allegation of abuse is immediately reported to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A specific resident reported to an inspector that there was no shower on second floor. The resident shared they received a shower in the tub but their preference would be to have an actual shower.

Review of the home's second floor bath schedule indicated that ten residents were to receive showers on their scheduled bath days.

A review of the identified ten resident's clinical health records, indicated that the resident's preference of bathing was to have a shower.

Interview with the Maintenance person revealed that the shower on second floor had not been operational for at least one month.

Interview with a Personal Support Worker confirmed that residents on the second floor who were identified to prefer showers had been receiving baths because the shower on the second floor was not operational. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Chart review revealed documentation by a member of the registered staff of an area of altered skin integrity on a resident.

Interview with a member of the registered staff confirmed that weekly reassessments of a residents altered skin integrity should be completed and documented by a member of the registered staff in the resident's clinical health record under progress notes.

Interview with a member of the registered staff confirmed that the weekly reassessment for 3 specific residents who had altered skin integrity were not completed.

Interview with the Interim Executive Director verified it is the home's expectation that residents exhibiting altered skin integrity, will be reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were schedules and procedures in place for preventative and remedial maintenance as part of the organized program of maintenance services under clause 15 (1) (c) of the Act.

During a tour of the home it was identified that there were no procedures or schedules in place for the preventative maintenance checks of the resident-staff communication and response system, exhaust system, floors, walls, doors, windows, fixtures, beds, furnishings, lights, ceilings, toilets, sinks, grab bars and other common surfaces/items of the home. The home's maintenance program was largely remedial, relying on the initiatives of employees to document their observations in a maintenance log book in order to be addressed. Areas of deficiencies identified were:
a) The resident-staff communication and response system
b) Flooring material was lifting and split
c) Corner wall damage and peeling paint
d) Heavily stained ceiling tiles
e) Noisy exhaust fans
f) Vanity in a tub room was in poor condition with exposed particle board [s. 90. (1) (b)]

Additional Required Actions:

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

WN #10: 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 when restraining a resident by a physical device, staff applied the physical device in accordance with any manufacturer's instructions.

Observations made by an inspector revealed a restraint was not applied correctly.

Interview with a Personal Support Worker confirmed that the restraint was applied loosely.

The Interim Executive Director verified it is the home's expectation that a restraint would be applied appropriately following the manufacturer's instructions. [s. 110. (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 to ensure that when restraining a resident by a physical device, staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Chart review for a specific resident revealed physician's order for a medication with specific directions.

Observations revealed the medication was given without following the specific directions.

Interview with a member of the registered staff confirmed that the medication had been given without following the specific directions.

Interview with a member of the registered staff verified it is the home's expectation that medications will be administered as prescribed by the physician. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observations of a meal service revealed staff serving soda crackers to residents and placing the crackers directly onto the table surface.

Interview with the Food Service Manager revealed using a bread and butter plate would be a better alternative for the soda crackers rather than placing them directly on the table surface.

Interview with the Food Services Manager confirmed the home's expectation is that staff participate in the implementation of the infection prevention and control program when serving resident meals. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 the following rights of residents are fully respected and promoted: 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.

During an interview a resident shared he/she is being treated roughly, verbally and physically by some staff of the home. This resident indicated as a result of this action, he/she experienced increased pain.

The Interim Executive Director was notified of this concern on January 27, 2015 and an investigation was initiated.

Interview with the Interim Executive Director revealed it is the home's expectation that all residents will be treated with courtesy and respect. [s. 3. (1) 1.]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Observations made during the initial tour of the home revealed the half door in a servery open and a hot steam table was accessible to residents posing a potential safety risks to any confused residents in the area as there were no staff in the area at the time.

Interview with the Food Services Manager, confirmed the home's expectation is that the door is locked when the servery is left unattended ensuring that the home is a safe and secure environment for its residents. [s. 5.]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response is provided to the Residents' Council within 10 days of receiving Residents' Council advice related to concerns or recommendations

Review of Residents' Council minutes revealed concerns:
a) related to Smoke coming into the home from smokers too close to the building and when the door opened, smoke came in . This concern was documented as sent to the Administrator
b) related to 4 mattresses . This concern was documented as sent to the Director of Nursing.
c) no documented responses to the above concerns

Interview with the Program manager revealed no written responses to the concerns raised by Residents' Council in 2014 could be found.

Interview with Interim Executive Director revealed it is the home's expectation that a written response is completed within 10 days of receiving the concerns from Residents' Council. [s. 57. (2)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the satisfaction survey results were acted upon.

Interview with the peopleCare Vice President of Care and Services revealed:
a) the home did seek advice of the Residents' Council in developing the satisfaction survey.
b) no resident satisfaction survey was completed, therefore no action plan developed on the results.
c) on a go forward, it is the home's expectation that the satisfaction survey will be completed annually and an action plan developed from the results. The results will be shared with the Resident's Council and the Council will have input into the action plan. [s. 85. (3)]

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

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented for cleaning of resident bedrooms, floors, privacy curtains and wall surfaces, as part of the organized program of housekeeping under clause 15 (1) (a) of the Act.

Observations revealed:
a) Soiled/stained privacy curtains
b) Walls were visibly soiled
c) Cob webbing in rooms
d) Floors were visibly scuffed

Interview with the Interim Executive Director confirmed the above observations and verified it is the home's expectation that there will be an organized program for the cleaning of resident rooms, floors, prviacy curtains and wall surfaces. [s. 87. (2) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (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 and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home was undertaken promptly after the licensee becomes aware of it.

Interview and record review conducted failed to identify an analysis of every incident of abuse or neglect of a resident.

Action was taken with regard to a report of alleged verbal abuse of a resident, however, no record of risk meetings whereby the analysis of an incident was discussed and documented could be located within the home.

Interview with the Vice President Care and Services identified that it is the expectation that the management team of the home analyze each incident of abuse or neglect at the team's monthly risk meeting. [s. 99. (a)]

Issued on this 9th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOAN WOODLEY (172), BERNADETTE SUSNIK (120), BONNIE MACDONALD (135), DEBORA SAVILLE (192), TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2015_228172_0006
Log No. / Registre no:	L-001727-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 6, 2015
Licensee / Titulaire de permis :	GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC 704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3
LTC Home / Foyer de SLD :	GOLDEN YEARS NURSING HOME 704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3
	NANCY KAUFFMAN-LAMBERT

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

To GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare and submit a plan that summarizes how the various identified areas of the home will be evaluated for adequate illumination levels and by whom. The plan shall include a schedule of time frames for compliance for the various deficient areas.

The plan shall be submitted to Bernadette.Susnik@ontario.ca by June 30, 2015. The plan shall be fully implemented by March 31, 2016.

Grounds / Motifs :

1. The licensee did not ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and is therefore subject to lighting requirements under the section of the lighting table titled "All Other Homes".

Lighting levels were measured in tub rooms, common spaces, dining areas, resident bedrooms, ensuite bathrooms and corridors. Outdoor conditions were bright and natural daylight was excluded as much as possible by pulling window covers. All light fixtures were turned on if not already illuminated and allowed to warm up. Using a hand held lighting meter, held 30 inches above and parallel to the floor, readings were taken which provided inadequate illumination. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Order / Ordre :

The licensee shall prepare and submit a plan which summarizes how the indoor air temperature of resident rooms will be monitored, by whom and how often. The plan shall include a copy of the home's indoor air temperature policy which shall describe how the indoor environment will be maintained at a minimum of 22C and what options and interventions would be available to staff and residents should the air temperatures fall below 22C.

The plan and policy shall be submitted to Bernadette.Susnik@ontario.ca by March 1, 2015. The plan shall be implemented by March 31, 2015.

Grounds / Motifs :

1. The licensee did not ensure that the temperature of the home was maintained at a minimum of 22 degrees Celcius (C).

Residents reported feeling cold in various sections of the home between January 20, 2015 and January 27, 2015. Outdoor air temperatures were between -15C and -5C during this time period. On January 27, 2015, between 10 and 11:45 a.m., indoor air temperatures were taken in rooms by placing a digital thermometer on furniture as close to the centre of the room as possible and away from windows and forced air heating grilles. Windows were noted to be closed in all cases and in some instances, plastic was observed to be over the windows. The thermometer was left in each room 15-25 minutes. The readings were below 22'C.

On January 28, 2015, indoor air temperatures were taken at 9:30 a.m. in 3 rooms . The temperatures were below 22'C. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 6th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JOAN WOODLEY

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