Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Oct 14, 2014;	2014_189120_0028 (A2)	H-000439-14/ H-000443-14	Resident Quality Inspection

Licensee/Titulaire de permis

NIAGARA INA GRAFTON GAGE HOME OF THE UNITED CHURCH
413 Linwell Road, St. Catharines, ON, L2M-7Y2

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

INA GRAFTON-GAGE HOME
413 Linwell Road, St Catharines, ON, L2M-7Y2

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

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BERNADETTE SUSNIK (120) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The following attached reports have been amended. Compliance dates for Orders #002, #007 and #008 have been extended as per the request of the Licensee.

Issued on this 14 day of October 2014 (A2)

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

Ontario

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

BERNADETTE SUSNIK (120) - (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): April 28, 29 and 30, 2014

This inspection was conducted in conjunction with the Resident Quality Inspection (2014-250511-0010).

During the course of the inspection, the inspector(s) spoke with the Director of Care, Environmental Services Supervisor, maintenance and housekeeping staff, registered staff, residents and personal support workers.

During the course of the inspection, the inspector(s) toured the 1st floor of Building "B" identified as the Long Term Care Home, measured lighting levels, observed resident bed systems, reviewed maintenance, housekeeping and infection prevention and control policies and procedures and tested door security and resident-staff communication and response systems.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Critical Incident Response

Infection Prevention and Control

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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. 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. (1).
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).

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).

1.1. All doors leading to secure outside areas that preclude exit by a resident,

including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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

Findings/Faits saillants :

1. The licensee did not ensure that;

1. Doors to which residents had access and that led to outdoor areas that were not secured were equipped with a door access control system, and
2. Doors leading to stairways to which residents had access, were equipped with an audible door alarm that allowed calls to be canceled only at the point of activation, and
3. Doors leading to stairways and outdoor areas that are not secured to which residents had access, were connected to the resident-staff communication and response system or to an enunciator located at the nurse's station with audio and visual capabilities.

The first floor of Building "B" was identified to be the long-term care home and was therefore evaluated for compliance with door and security legislation. Many of the doors and non-long term care home areas were not adequately secured. Two doors were installed with magnetic locking devices, one on each side of a long corridor where residents' rooms were located. These doors have served to segregate residents from their activity room, dining room, main lobby, hair salon, library/chapel and cafe.

1. Two glass doors were located in the resident's dining room that were not locked and that led to an outdoor area that was not secured. The outdoor area led directly to a busy road and other areas of the property. The dining room is used by both long term care residents and tenants from the upper floors. The Environmental Services Supervisor reported that the dining room is locked between meals and residents would not have access. Residents however are required to have access to their dining room should they wish between meals.

2. Four stairwell doors (G16, G46, next to #1134 and next to #1142) to which

residents had access were identified within the long term care home. None of these stairwell doors were connected to an audible alarm when tested. Sound boxes were observed attached behind the key pads for these doors. Staff were interviewed and reported that the stairwells alarmed in the past but were disconnected.

3. An open stairwell was identified in the main lobby of the long-term care home. The open stairwell led down to a basement which led to unsecure outdoor areas and non-residential areas. The stairwell was not secured in any manner to prevent residents from gaining access to the basement.

4. The four stairwells identified in #2 above were not connected to the resident-staff communication and response system known as the Versus System. An enunciator panel was not available at the nurse's station as the alternative option in which to connect the doors.

5. The main door located in the lobby of the first floor was equipped with a magnetic locking system, however the system was not connected to the resident-staff communication and response system known as the Versus System. An enunciator panel was not available at the nurse's station as the alternative option in which to connect the doors.

6. Access to Building "A" which is a non-long term care area was located on the first floor. This area did not have any doors in which to lock in order to prevent unsupervised resident access to the area. [s. 9. (1)]

2. The licensee did not ensure that doors that led to the outdoor secured courtyard were equipped with locks to restrict unsupervised access to the area by residents.

1. Eleven private resident rooms, the activity room and the library did not have locks on the doors. Each of the eleven resident rooms were equipped with a sliding glass patio door with locks and with restriction devices to prevent the door from sliding open more than approximately 6 inches. However, the restriction device was easily manipulated to allow the door to open fully. The locking mechanism was a simple push/pull button that would not prevent residents from unlocking the door and entering the courtyard unsupervised. The risk of injury or death, especially in winter is high for those residents who cannot be seen leaving their room to enter the courtyard.

2. Two glass doors which open by releasing a bar across the width of the door were located in resident accessible areas. The doors were not equipped with locks and led

to an enclosed outdoor courtyard. One was located in the activity room and one in the library/chapel. Although the residents were required to use a code to exit a set of doors to get into these areas, cognitively well residents were able to independently gain access to these spaces if they wished. [s. 9(1) 1.1.]

3. The licensee did not ensure that any locks on bedrooms were designed and maintained so that they could be readily released from the outside in an emergency.

Dead bolt locks were identified on each of the 40 resident bedroom doors. The locks were not designed so that they could readily be released from the outside by any person during an emergency. Staff were required to carry a key, which may be lost or forgotten to be carried in order to open a door. Key locks are not readily releasable. [s. 9.(1) 3.]

Additional Required Actions:

CO # - 001, 004, 005 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. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. Where bed rails are used, the licensee was not able to produce confirmation that residents' bed systems were evaluated in accordance with evidence-based practices (Health Canada Guidelines titled "Adult Hospital Beds: Patient Related Entrapment Hazards, Side Rail Latching Reliability and Other Hazards") to minimize risk to the resident.

The home's bed systems were identified to be over 15 years of age along with mattresses that were of an unknown age. Aging mattresses and older model beds are highly likely to have one or more entrapment zones. Bed systems were observed to be equipped with either 1/4 or 3/4 rails. One in particular (#1121) had a very different rail from the other beds and appeared to have large gaps between the rails . Residents were observed in bed with both 3/4 rails in the raised position (engaged) in two identified rooms on April 28, 2014. Several bed frames were observed to be equipped with therapeutic surfaces which compressed easily. These mattresses if used in conjunction with a rail, present a high risk of entrapment to the resident. [s. 15. (1)(a)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 002

WN #3: 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 was not easily seen, used or accessible to residents, staff and visitors at all times.

The home's resident-staff communication and response system (RSCRS) was evaluated for accessibility, functionality and ease of use. The system consisted of pagers worn by staff, wireless pendants worn by staff, wireless pendants worn by most residents and wall mounted activation stations in the tub room and resident washrooms. In order to activate the system, residents or staff had to press a button on the pendant in order to alert staff that assistance was required in a particular location. When residents were observed and interviewed, not all residents had a pendant that was accessible to them in their bedroom, dining room, activity room, library/chapel or kitchenette/lounge. Approximately 12 pendants were not made available to 12 residents and therefore indirectly to their visitors.

1. Resident #009 had a cognitive impairment, arthritis and spent most of their time in their wheelchair. Between April 29 and May 2, 2014 resident #009 stated that they did not know where their pendant was and that they didn't know how they would call a staff person if they required assistance. The inspector could not locate a pendant anywhere in the resident's room. The resident's pendant or system could not be accessed or used by the resident. (526)
2. Resident #022 had cognitive impairment. They were observed to be in bed on April 28, 2014 and April 30, 2014 with no access to a pendant. When the resident was

asked how they would call for assistance they stated that they would yell for a nurse. Clinical records indicated that the resident no longer understood how to use the pendant which normally hung around the resident's neck, and had repeatedly removed the pendant and forgot where they put it. Interview with the Director of Resident Care (DRC) confirmed the resident was no longer able to use the pendant and it was removed. The DRC provided a list of 12 identified residents that were no longer able to use the pendants and confirmed that the pendant was removed from the identified residents. (511)

Use of a pendant, which is worn by some residents and by nursing staff, was the only way to make a call for assistance from certain identified bedrooms, the activity room, the library/chapel, the kitchenette/lounge and the dining room. The resident-staff communication and response system was therefore not easily accessed and used in every identified area, by residents, non-nursing staff, and visitors. [s. 17(1)(a)]

2. The resident-staff communication and response system (RSCRS) was not on at all times. On April 15, 2014, the system ceased to work when the home switched over from city provided hydro to a back-up generator. The RSCRS was not connected to a back up battery and during the short time between city and generator power, the system crashed, losing connectivity to the pendants, pagers and ceiling sensors. The RSCRS was non-functional for approximately 4 hours until all 40 resident pendants and over 5 staff pendants were re-programmed.

Secondly, during the inspection between April 28 and 30, 2014, the Inspector identified fifteen wall mounted activation stations located in resident bathrooms and a tub room and several pendants to be non-functional due to dead or low battery power. The activation stations and pendants, as essential components of the RSCRS were not functional and therefore not "on". [s. 17(1)(b)]

Additional Required Actions:

CO # - 003, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Findings/Faits saillants :

1. The licensee failed to maintain the minimum lighting requirements throughout the home as set out in the lighting table.

Lighting levels were measured in corridors, several resident bedrooms and washrooms, and at the reading position of one resident bed. The outdoor conditions were sunny when corridors and bathrooms were tested and cloudy with rain when bedrooms and bathrooms were tested. A Sekonic Handi Lumi illumination meter was used to test the lighting levels, held 30 inches above the floor level where required.

On April 28, 2014, the corridors were observed to be equipped with fluorescent tube lights behind wooden valences on one side of the 2 corridors where the rooms were located. No overhead lighting was provided. The carpets were dark in colour. While traveling along the corridor, a lux of 25-170 was measured along a portion of the corridor where the resident room doors were closed. The lighting was not maintained

at a consistent and continuous level of 215.28 lux.

On April 29, 2014, resident rooms were observed to be equipped with two wall mounted lighting fixtures (with 2 spiral fluorescent bulbs each) for overall room lighting. In room #1120, the available blinds on the windows were closed and all available lighting fixtures turned on. The two wall fixtures were both 125 lux when standing directly in front of them. Centrally, in the room at the bed, the lighting level was 20 lux. The minimum level required is 215.28 lux.

With respect to the level of lux for reading lights, this was difficult to confirm as the home did not provide residents with a standard reading light. Most residents had their own personal reading lamp which were all different in size, height and illumination levels. On April 30, 2014, the Environmental Services Supervisor was shown how lighting is typically measured in one resident room at the head of the bed at a reading position. The lux was well below the required level of 376.73.

On April 28, 2014, resident washrooms were observed to be equipped with one pot light near the shower enclosure and one light was mounted on the wall over the vanities which consisted of two regular incandescent light bulbs. In the washroom of #1139, the lux was 20 central in the room and 115 lux over the vanity. Rooms 1137 & 1136 were both 110 lux over the vanity (each had one bulb burnt out). Lights were burnt out in washrooms 1135, 1134, 1122, 1116, 1106, 1104, 1107, 1109 which created even lower illumination levels. The minimum required lux level is 215.28.

No lighting measurements were taken in the activity room and tub room as the rooms appeared adequately lit. The dining room was very large with chandeliers and could not be measured due to the inability to control for outdoor light seepage.

Non compliance was identified on July 18, 2012 and a written notification issued with a voluntary plan of compliance. No plans were in place to address the non-compliance. [s. 18.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 007

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the elevators located in the Long-term care home were equipped with a device or access codes to prevent resident access to either the basement or to the upper floors. These areas all led to unsecured outdoor areas and unlocked stairwells. [s. 10(1)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 008

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the home had sufficient indoor furnishings to meet the needs of residents. The home's literature for new residents was reviewed and specified that the home provides residents with a bed and linens and that all other furniture may be brought in by the resident. Confirmation was made by visiting the home's storage rooms with the Environmental Services Supervisor where no additional required furniture such as night tables, lamps and easy chairs were available. In visiting resident rooms, #1105 and #1134 were missing reading lights. All other furniture appeared to belong to residents. The home was not able to demonstrate that they could provide a new resident with the required furniture or replace a piece of furniture should it become unsafe. [s. 12(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 the home has sufficient indoor furnishing to meet the needs of residents, to be implemented voluntarily.

WN #7: 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 did not ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance.

The home's procedure (ES-08-02-09 August 2004) was developed for the home's resident-staff communication and response system which is a wireless system called Versus. The procedure was identified to be missing information related to how various components of the system such as the pendants, pagers and ceiling sensors would be tested for functionality. The policy requires that the system be inspected quarterly. No formal inspections were conducted of the system and it's components for at least one year. The system had not been scheduled for an audit at the time of inspection as the new Environmental Services Supervisor was not aware of how the system functioned. During the inspection between April 28 and 30, 2014, the Inspector identified fifteen wall mounted activation stations located in resident bathrooms and a tub room and several pendants to be non-functional due to dead or low battery power. Other aspects of the system were also found to be not operating properly. A resident's pendant did not activate a staff pager when pressed for assistance while in the dining room but was able to activate the pager from the activity room. The administrator reported that they were not able to obtain technical support or obtain parts for the system when it failed on April 15, 2014. However, the Versus company when contacted by the Inspector, did in fact have technicians and support services available to ensure the system functions properly and is used to it's full capacity and was available for an annual fee.

Procedure (ES-08-01-23 August 2011) was developed for the home's interior surfaces such as walls. The procedure required wall repairs to be on-going. Two rooms were identified to have major wall damage. Room 1111 had most of the walls in the bedroom and at least one wall in the bathroom with large holes. The resident was using an electrical scooter up until April 14, 2014 and had damaged the walls. Room 1121 also had multiple holes in the wall. Neither room was scheduled to have the walls repaired. In general, the home did not have any schedules in place related to ongoing wall preventive and remedial maintenance.

No procedures were developed to ensure that furnishings such as bathroom cabinets were maintained in good condition. Cabinets identified but not limited to resident bathrooms #1127, 1126, 1125,1132, 1133 and tub room no longer had surfaces that were smooth, tight-fitting and easy to clean. The laminate surfaces along the bottom of the cabinets had deteriorated and the particle board underneath was exposed.

No procedures or schedules were developed to ensure that light bulbs are replaced when they burn out. Light bulbs in 1135, 1134, 1136, 1137, 1122, 1116, 1106, 1104, 1107, 1109 were identified to be burnt out. Maintenance staff reported that they do walk through the home to conduct a visual audit for burnt out lights and other issues, however they do not always have time to replace them. Nursing staff do not always complete a requisition for burnt out lights to be replaced. No schedule was in place to replace the burnt out lights.

The Environmental Services Supervisor, who has been with the home less than one year reported that the policy and procedure manual was under revision. This was noted at the time of inspection as the procedures were being reviewed. [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 routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #8: 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. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) 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. 229 (2).

Findings/Faits saillants :

1. The infection prevention and control program has not been evaluated and updated annually. The home's policies and procedures related to cleaning and disinfection and outbreak control measures have not been revised as per the various best practices documents written by the Provincial Diseases Advisory Committee (PIDAC).

The home's policy IC-02-13-03 titled "Droplet Precautions" dated November 2008 identified that staff are to wear gloves for all direct care (bathing, washing, changing clothes, dressing). As per the PIDAC documents, it states that staff "wear gloves when it is anticipated that the hands will be in contact with mucous membranes, non-intact skin, tissue, blood, body fluids, secretions, excretions, or equipment and environmental surfaces contaminated with the above." Gloves are not recommended for use when dressing a resident, making their beds, grooming them or washing or bathing them. The policy and procedures have not been updated to reflect the current best practice or to ensure that resident's are treated with dignity.

The home's policy IC-02-13-03 titled "Droplet Precautions" dated November 2008

stated that residents must wear a mask when leaving his or her room. Best practices requires that residents be assessed if they are able or if they can tolerate wearing a mask. Residents rights have not been taken into consideration. The wearing of a mask is not a requirement.

The home's policy IC-02-13-03 titled "Droplet Precautions" dated November 2008 requires residents to be isolated to their room when on droplet precautions (when a resident is coughing or sneezing). Two residents were observed to be in their rooms all throughout the day on April 28, 29 and 30, 2014. They also received their meals in their rooms. Although the staff stated that they did not force residents to be confined to their rooms, these residents and their families when interviewed believed that they were not allowed to go to the dining room or to the activity room. The policy did not clarify what the resident's rights were when being monitored for minor symptoms and what precautions staff may or may not enforce.

The home's policy IC-02-14-01 dated August 2004 titled "Soiled Linens/Isolation Linens" has not been updated to reflect current best practices identified by PIDAC. The policy directs staff to rinse feces from soiled linens in a hopper prior to sending to laundry. This is no longer advised due to cross-contamination issues from using a spray hose. The home's policy directs staff to segregate linens if they are from residents who have a "potentially communicable disease". During the inspection, two resident rooms were observed to have separate linen hampers outside the rooms for soiled linens. This practice is no longer advisable as all linen is to be handled exactly the same regardless of the resident's suspected diagnosis. Laundry processing remains the same with all linens, regardless of the type of contaminants.

The home did not have appropriate facilities in which to deep clean and disinfect plastic articles such as bed pans, urinals and washbasins. The Director of Care (DRC) reported that staff on evening shift had been given the responsibility to spray the plastic articles with a disinfectant and use paper towel while in the resident's washroom. The home was not equipped with any sinks in which to submerge or soak heavily soiled items. The DRC had not considered the necessity to ensure that all plastic personal items are deep cleaned on a regular basis to remove build-up that may not have been removed during the daily spray-in-place disinfection process. [s. 229(2)(d)]

2. A written record of the annual infection prevention and control program evaluation was not kept as the program had not been evaluated for 6 years. [s. 229(2)(e)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4).

s. 230. (5) The licensee shall ensure that the emergency plans address the following components:
1. Plan activation. O. Reg. 79/10, s. 230 (5).
2. Lines of authority. O. Reg. 79/10, s. 230 (5).
3. Communications plan. O. Reg. 79/10, s. 230 (5).
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

Findings/Faits saillants :

1. The home's emergency plans did not include information or direction for staff in dealing with the loss of the resident-staff communication and response system (RSCRS), which is considered an essential service.

On April 15, 2014, the RSCRS failed for a period of approximately 4 hours. Staff, residents or visitors did not have any back-up method in which to call for assistance if required. None of the existing plans identified what course of action could be taken in such an event. [s. 230(4)1.]

2. The licensee's emergency plans, dated either August 2004, May 2004 or January 2009 consisted of 7 different colour-coded emergency types. Specifically, the contingencies related to the loss of essential services (loss of heat, power failure) were very vague and did not address lines of authority, a communications plan or specific staff roles and responsibilities. [s. 230(5)]

3. The emergency plans were not updated at least annually. The emergency plans available to staff were dated August 2004, May 2004 and January 2009. [s. 230(6)]

Issued on this 14 day of October 2014 (A2)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Hamilton Service Area Office
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : BERNADETTE SUSNIK (120) - (A2)

Inspection No. / No de l'inspection : 2014_189120_0028 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-000439-14/ H-000443-14 (A2)

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

Report Date(s) / Date(s) du Rapport : Oct 14, 2014;(A2)

Licensee / Titulaire de permis : NIAGARA INA GRAFTON GAGE HOME OF THE UNITED CHURCH
413 Linwell Road, St. Catharines, ON, L2M-7Y2

LTC Home / Foyer de SLD : INA GRAFTON-GAGE HOME
413 Linwell Road, St Catharines, ON, L2M-7Y2

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l’administratrice ou de l’administrateur : PATRICK O'NEILL

To NIAGARA INA GRAFTON GAGE HOME OF THE UNITED CHURCH, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

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

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

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

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

Order / Ordre :

The licensee shall:

1. Equip stairwell doors (G16, G46, next to #1134 and next to #1142) with a functioning audible alarm which can only be canceled at the point of activation.
2. Connect all four stairwell doors (G16, G46, next to #1134 and next to #1142) and the main foyer door to the resident-staff communication and response system.
3. Equip the glass exit doors located in the activity room and library/chapel with a locking system that cannot be easily manipulated by residents.
4. Secure the open staircase in the main foyer so that residents cannot gain access to the basement unsupervised.
5. Secure the non-residential area known as Building "A" from the long-term care home located in Building "B".

Grounds / Motifs :

1. The licensee did not ensure that;

1. Doors to which residents had access and that led to outdoor areas that were not secured were equipped with a door access control system, and
2. Doors leading to stairways to which residents had access, were equipped with an audible door alarm that allowed calls to be canceled only at the point of activation, and
3. Doors leading to stairways and outdoor areas that are not secured to which residents had access, were connected to the resident-staff communication and response system or to an enunciator located at the nurse's station with audio and visual capabilities.

The first floor of Building "B" was identified to be the long-term care home and was therefore evaluated for compliance with door and security legislation. Many of the doors and non-long term care home areas were not adequately secured. Two doors were installed with magnetic locking devices, one on each side of a long corridor where residents' rooms were located. These doors have served to segregate residents from their activity room, dining room, main lobby, hair salon, library/chapel and cafe.

1. Two glass doors were located in the resident's dining room that were not locked

and that led to an outdoor area that was not secured. The outdoor area led directly to a busy road and other areas of the property. The dining room is used by both long term care residents and tenants from the upper floors. The Environmental Services Supervisor reported that the dining room is locked between meals and residents would not have access. Residents however are required to have access to their dining room should they wish between meals.

2. Four stairwell doors (G16, G46, next to #1134 and next to #1142) to which residents had access were identified within the long term care home. None of these stairwell doors were connected to an audible alarm when tested. Sound boxes were observed attached behind the key pads for these doors. Staff were interviewed and reported that the stairwells alarmed in the past but were disconnected.

3. An open stairwell was identified in the main lobby of the long-term care home. The open stairwell led down to a basement which led to unsecure outdoor areas and non-residential areas. The stairwell was not secured in any manner to prevent residents from gaining access to the basement.

4. The four stairwells identified in #2 above were not connected to the resident-staff communication and response system known as the Versus System. An enunciator panel was not available at the nurse's station as the alternative option in which to connect the doors.

5. The main door located in the lobby of the first floor was equipped with a magnetic locking system, however the system was not connected to the resident-staff communication and response system known as the Versus System. An enunciator panel was not available at the nurse's station as the alternative option in which to connect the doors.

6. Access to Building "A" which is a non-long term care area was located on the first floor. This area did not have any doors in which to lock in order to prevent unsupervised resident access to the area. (120)

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

Dec 31, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The license shall evaluate all resident bed systems using the Health Canada Guidelines titled "Adult Hospital Beds: Entrapment Hazards, Side Rail Latching Hazards and other Hazards". Once completed, the licensee shall mitigate any risks to residents where beds have not passed zones 1-4.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. Where bed rails are used, the licensee was not able to produce confirmation that residents' bed systems were evaluated in accordance with evidence-based practices (Health Canada Guidelines titled "Adult Hospital Beds: Patient Related Entrapment Hazards, Side Rail Latching Reliability and Other Hazards") to minimize risk to the resident.

The home's bed systems were identified to be over 15 years of age along with mattresses that were of an unknown age. Aging mattresses and older model beds are highly likely to have one or more entrapment zones. Bed systems were observed to be equipped with either 1/4 or 3/4 rails. One in particular (#1121) had a very different rail from the other beds and appeared to have large gaps between the rails . Residents were observed in bed with both 3/4 rails in the raised position (engaged) in two identified rooms on April 28, 2014. Several bed frames were observed to be equipped with therapeutic surfaces which compressed easily. These mattresses if used in conjunction with a rail, present a high risk of entrapment to the resident. (120)

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

Nov 17, 2014(A2)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

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

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 shall;

1. Install a functional wall mounted activation station in a visible location in the dining room, in the activity room, library/chapel, hair salon, small lounge/kitchen and any other common area to which residents have access.
2. A wireless and functional pendant shall be made available in each resident bedroom so that it can be easily seen and accessed by anyone. An alternative option would be to install a functional wall mounted activation station next to each resident bed.

Grounds / Motifs :

1. The resident-staff communication and response system was not easily seen, used or accessible to residents, staff and visitors at all times.

The home's resident-staff communication and response system (RSCRS) was evaluated for accessibility, functionality and ease of use. The system consisted of pagers worn by staff, wireless pendants worn by staff, wireless pendants worn by most residents and wall mounted activation stations in the tub room and resident washrooms. In order to activate the system, residents or staff had to press a button on the pendant in order to alert staff that assistance was required in a particular location. When residents were observed and interviewed, not all residents had a pendant that was accessible to them in their bedroom, dining room, activity room, library/chapel or kitchenette/lounge. Approximately 12 pendants were not made available to 12 residents and therefore indirectly to their visitors.

1. Resident #009 had a cognitive impairment, arthritis and spent most of their time in a wheelchair. Between April 29 and May 2, 2014 resident #009 stated that they did not know where their pendant was and that they didn't know how they would call a staff person if they required assistance. The inspector could not locate a pendant anywhere in the resident's room. The resident's pendant or system could not be accessed or used by the resident. (526)
2. Resident #022 had cognitive impairment. The resident was observed to be in their bed on April 28, 2014 and April 30, 2014 with no access to a pendant. When asked how they would call for a assistance they stated they would yell for a nurse. Clinical records indicated that the resident no longer understood how to use the pendant which normally hung around the resident's neck, and had repeatedly removed the pendant and forgot where they put it. Interview with the Director of Resident Care (DRC) confirmed the resident was no longer able to use the pendant and it was removed. The DRC provided a list of 12 identified residents that were no longer able to use the pendants and confirmed that the pendant was removed from the identified residents. (511)

Pendants were the only source in which to call from for assistance from a bedroom, activity room, library, kitchenette/lounge or dining room. Pendants were therefore not accessible in all areas visited by residents and visitors. (120)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Dec 31, 2014

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. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

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

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

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

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

Order / Ordre :

The licensee shall restrict the sliding glass patio doors located in resident rooms #1123-1133 so that they are not able to be easily manipulated by staff, residents or family to open greater than 15 cm.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee did not ensure that doors that led to the outdoor secured courtyard were equipped with locks to restrict unsupervised access to the area by residents.

1. Eleven private resident rooms, the activity room and the library did not have locks on the doors. Each of the eleven resident rooms were equipped with a sliding glass patio door with locks and with restriction devices to prevent the door from sliding open more than approximately 6 inches. However, the restriction device was easily manipulated to allow the door to open fully. The locking mechanism was a simple push/pull button that would not prevent residents from unlocking the door and entering the courtyard unsupervised. The risk of injury or death, especially in winter is high for those residents who cannot be seen leaving their room to enter the courtyard. (120)

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

Jul 26, 2014(A1)

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

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

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

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

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

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

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

Order / Ordre :

The licensee shall remove all locks from resident bedroom doors.

Ontario

Ministry of Health and Long-Term Care

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Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee did not ensure that any locks on bedrooms were designed and maintained so that they could be readily released from the outside in an emergency.

Dead bolt locks were identified on each of the 40 resident bedroom doors. The locks were not designed so that they could readily be released from the outside by any person during an emergency. Staff were required to carry a key, which may be lost or forgotten to be carried in order to open a door. Key locks are not readily releasable. (120)

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

Jul 15, 2014(A1)

Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

Ontario

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 shall ensure that the resident-staff communication and response system is on at all times by;

1. Installing a back-up battery and ensuring that it is connected to the homes back up generator, and
2. Replacing all dead batteries on pendants and wall mounted activation stations and ensuring that a routine is established for battery replacement.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The resident-staff communication and response system (RSCRS) was not on at all times. On April 15, 2014, the system ceased to work when the home switched over from city provided hydro to a back-up generator. The RSCRS was not connected to a back up battery and during the short time between city and generator power, the system crashed, losing connectivity to the pendants, pagers and ceiling sensors. The RSCRS was non-functional for 6 hours until all 40 resident pendants and over 5 staff pendants were re-programmed.

Secondly, during the inspection between April 28 and 30, 2014, the Inspector identified fifteen wall mounted activation stations located in resident bathrooms and a tub room and several pendants to be non-functional due to dead or low battery power . The activation stations and pendants, as essential components of the RSCRS were not functional and therefore not "on". (120)

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

Jun 30, 2014

Order # /
Ordre no : 007

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 :

(A2)
The licensee shall prepare and submit a plan that summaries how the lighting levels throughout the long term care home will comply with the requirements as set in the lighting table.

The plan shall be submitted to Bernadette.susnik@ontario.ca by email or by fax to 905-546-8255 by August 29, 2014.
The plan shall be fully implemented by November 17, 2015.

Grounds / Motifs :

1. The licensee failed to maintain the minimum lighting requirements throughout the

home as set out in the lighting table.

Lighting levels were measured in corridors, several resident bedrooms and washrooms, and at the reading position of one resident bed. The outdoor conditions were sunny when corridors and bathrooms were tested and cloudy with rain when bedrooms and bathrooms were tested. A Sekonic Handi Lumi illumination meter was used to test the lighting levels, held 30 inches above the floor level where required.

On April 28, 2014, the corridors were observed to be equipped with fluorescent tube lights behind wooden valences on one side of the 2 corridors where the rooms were located. No overhead lighting was provided. The carpets were dark in colour. While traveling along the corridor, a lux of 25-170 was measured along a portion of the corridor where the resident room doors were closed. The lighting was not maintained at a consistent and continuous level of 215.28 lux.

On April 29, 2014, resident rooms were observed to be equipped with two wall mounted lighting fixtures (with 2 spiral fluorescent bulbs each) for overall room lighting. In room #1120, the available blinds on the windows were closed and all available lighting fixtures turned on. The two wall fixtures were both 125 lux when standing directly in front of them. Centrally, in the room at the bed, the lighting level was 20 lux. The minimum level required is 215.28 lux.

With respect to the level of lux for reading lights, this was difficult to confirm as the home did not provide residents with a standard reading light. Most residents had their own personal reading lamp which were all different in size, height and illumination levels. On April 30, 2014, the Environmental Services Supervisor was shown how lighting is typically measured in one resident room at the head of the bed at a reading position. The lux was well below the required level of 376.73.

On April 28, 2014, resident washrooms were observed to be equipped with one pot light near the shower enclosure and one light was mounted on the wall over the vanities which consisted of two regular incandescent light bulbs. In the washroom of #1139, the lux was 20 central in the room and 115 lux over the vanity. Rooms 1137 & 1136 were both 110 lux over the vanity (each had one bulb burnt out). Lights were burnt out in washrooms 1135, 1134, 1122, 1116, 1106, 1104, 1107, 1109 which created even lower illumination levels. The minimum required lux level is 215.28.

No lighting measurements were taken in the activity room and tub room as the rooms

appeared adequately lit. The dining room was very large with chandeliers and could not be measured due to the inability to control for outdoor light seepage.

Non compliance was identified on July 18, 2012 and a written notification issued with a voluntary plan of compliance. No plans were in place to address the non-compliance. (120)

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

Nov 16, 2015(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Order / Ordre :

The licensee shall secure all elevators located on the first floor of the Long-term Care Home so that residents are not able to access the basement or the upper two floors unless supervised.

Grounds / Motifs :

1. The licensee did not ensure that the elevators located in the Long Term Care home were equipped with a device or access codes to prevent resident access to either the basement or to the upper floors. These areas all led to unsecured outdoor areas and unlocked stairwells. (120)

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

Dec 19, 2014(A2)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
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 14 day of October 2014 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK - (A2)

Service Area Office /
Bureau régional de services : Hamilton