Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 9, 2014	2014_321501_0003	T-44-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA
2 OVERLEA BLVD, TORONTO, ON, M4H-1P4

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

ISABEL AND ARTHUR MEIGHEN MANOR
155 MILLWOOD ROAD, TORONTO, ON, M4S-1J6

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

SUSAN SEMEREDY (501), AMANDA WILLIAMS (101), JOELLE TAILLEFER (211), JULIENNE NGONLOGA (502), STELLA NG (507)

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): March 14, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, 31 and April 1, 11, 2014.

This inspection occurred concurrently with complaint inspections #2014_321501_0004 (T-182-13), #2014_235507_0006 (T-582-13, T-192-14) and critical incident inspection #2014_219211_0010 (T-220-14, T-584-13).

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), assistant director of care (ADOC), designated day nurse, designated evening nurse, wound care nurse, registered nursing staff, personal support workers (PSWs), care clerk, food services manager, registered dietitian (RD), food services supervisor (FSS), dietary aides, social worker, director of human resources, co-ordinator of recreation and volunteers, continuous quality improvement co-ordinator, activation staff, maintenance worker, housekeeping staff, residents and substitute decision makers.

During the course of the inspection, the inspector(s) conducted observations and reviewed resident and home records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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 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 failed to ensure that the dining areas throughout the home are a safe and secure environment for its residents.

On March 14, 2014, inspector #501 observed that the dining room area on the east wing of the second floor secure unit has two entrances; one entrance had a wander strip across preventing access and the other entrance's wander strip was broken and had a resident in a wheelchair partially blocking the entrance. The floor of the dining room had just been washed and there were no wet floor signs to identify the slip

hazard. The inspector entered the dining room and observed that a small wooden set of swinging doors to the servery was unlocked. The inspector was able to gain access to a hot water machine and pour boiling hot water into a cup which had the potential to scald or burn cognitively impaired residents who gained access to this area. At this time, there were no staff members in sight. The inspector also observed from the server area that there was an unlocked sliding door leading to a dish washing area which had a commercial dishwasher that could potentially cause injury to residents who enabled this piece of equipment. A dietary aide appeared in the area and stated that the swinging doors are meant to be locked with a wooden bar, however many residents are able to remove this bar. The dietary aide also stated that the lock for the sliding doors to the dish washing area was not working.

On March 14, 2014, inspector #211 observed that the dining room areas on the west wing of the third and fourth floors each have two entrances and these entrances did not have barriers or wander strips to prevent access by residents. The inspector observed that in each dining room there was a set of small wooden swinging doors to the serveries which were open. The inspector was able to gain access to hot water machines which had the potential to scald or burn residents who accessed these areas. At this time, there were no staff members in sight. The inspector also observed from the servery areas that there were unlocked sliding doors leading to dish washing areas and service elevators. The dish washing areas had commercial dishwashers which could cause potential injury to residents who enabled this piece of equipment. On the third floor the service elevator had a key in it which could enable residents to gain further access to non-residential areas. Interview with a dietary aide on the third floor revealed that the lock for the swinging doors does not work because the hatch that holds the wooden bar is broken and confirmed he/she left the key in the elevator. Interview with registered staff on the fourth floor revealed the swinging doors are usually locked with a wooden bar but he/she could not find this bar at the moment.

Interview with the ED confirmed an awareness that the doors to the server areas were a risk to residents and the home had been looking at different options. [s. 5.]

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. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The home had an audit conducted by Shoppers Home Health dated July 15, 2013. The report identified that beds with old-quarter length rails did not pass the Dimensional Test for Bed Systems related to entrapment zones.
Recommendations were left for the home to replace all old one-quarter length rails with new ones because of risk for entrapment at zones 2 and 4.
On March 14, 24, and 26, 2014, the inspector observed that the beds in identified resident rooms had old one-quarter length rails. Interview with the DOC on March 26, 2014, revealed that the home has not ensured that all unsafe bed rails have been replaced since the audit of July 15, 2013. [s. 15. (1) (a)]

2. The home has not implemented interventions to address the audit report conducted by Shoppers Home Health Care. The ED and DOC provided the following additional information on April 11, 2014, of the 168 beds of the home:
- 154 beds failed the test for zones 2 and 4
- 12 beds with therapeutic surfaces were not tested. [s. 15. (1) (a)]

3. The home has not implemented interventions to address the audit report conducted by Shoppers Home Health Care. The ED and DOC provided the following additional information on April 11, 2014, of the 168 beds of the home:
- 154 beds failed the test for zones 2 and 4
- 12 beds with therapeutic surfaces were not tested. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, and are consistent with and complement each other.

On an identified date, a PSW indicated that resident #84 complained of pain while being transferred to a chair for breakfast and did not report the pain to the registered staff. The registered staff confirmed that he/she was not informed by the PSW that

resident #84 complained of pain. [s. 6. (4) (a)]

2. On an identified date, the inspector observed resident #228 wearing a restraint while seated in the wheelchair. Record review and staff interview revealed that an order for this restrain was not prescribed.

Interview with the ADOC confirmed that the restraint for resident #228 was also applied on identified dates. Registered staff interview revealed that the information to obtain an order from a physician was not clearly communicated to the team on identified dates, and as a result an order for this restraint was not obtained until an identified date. [s. 6. (4) (a)]

3. Record review revealed that the RD did not collaborate with the nursing staff in attaining an accurate weight for resident #003's initial nutrition assessment.

Review of progress notes revealed that nursing staff had weighed resident #003 on the day of admission and he/she weighed 65.7 kilograms. Review of the weight record revealed that nursing staff entered the weight as 165.7 kilograms. Review of the RD's initial nutrition assessment revealed that the weight of 165.7 kilograms was assumed to be in pounds and was converted to kilograms which resulted in a weight of 75.3 kilograms.

Interview with the DOC confirmed that the RD did not consult with the nursing staff regarding the admission weight that was entered and, as a result, an inaccurate weight was used in the initial nutrition assessment.

PLEASE NOTE: This evidence of non-compliance was found during inspection #2014_321501-0004. [s. 6. (4) (a)]

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

Record review revealed that resident #301 is at risk of choking due to difficulty of swallowing and physical limitation and requires assistance with eating. The plan of care states to position the resident at a 90 degree angle and ensure the resident remains upright for 30 minutes after meals.

On an identified date, resident #301 was observed being fed breakfast in bed and

positioned close to a 60 degree angle with his/her feet hanging over the end of the bed. The resident was leaning on his/her right side. On an identified date, resident #301 was observed being fed lunch in bed and positioned close to a 45 degree angle with his/her feet elevated. Interview with an identified PSW indicated that the position the resident was in, prevented the resident from sliding down. The inspector observed that the head and end of the bed was lowered to a flat position 5 minutes after the meal.

Interview with registered staff confirmed that resident #301 should be fed at a 90 degree angle and should remain upright for 30 minutes after meals. [s. 6. (7)]

5. The licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the content of the resident's plan of care and have convenient and immediate access to it.

Record review revealed and interview with registered staff confirmed that registered staff can access the plan of care from the computer and the PSWs can access the plans of care from a binder on each unit.

Interview with an identified PSW indicated that the plan of care for resident #94 is kept in the computer and he/she has no access to them. The PSW indicated he/she is aware of the plan of care for resident #94 because he/she has been working in the home for a long time, knows the resident well and receives reports from the registered staff at beginning of shifts. [s. 6. (8)]

6. The licensee failed to ensure that the provision of the care set out in the plan of care is documented.

Record review revealed that resident #167 is totally dependent for bathing and receives a bed bath twice a week.

Record review revealed that resident #167 was only given a bed bath two days in February and three days in March, 2014.

Interview with staff revealed that bed baths are given but are not consistently documented. [s. 6. (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 that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, the care set out in the plan of care is provided to the resident as specified in the plan, the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it and that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On March 18 and 31, 2014, the inspector observed that the arms of resident #129's wheelchair were dirty. Review of the cleaning schedule for wheelchairs revealed and interview with the DOC confirmed that the cleaning of this wheelchair was to take place on March 15, 2014, but did not occur. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home's furnishings and equipment are maintained in a safe condition and in a good state of repair.

On March 14 and 31, 2014, the inspector observed deep black scratches on the floor, ripped seats on five feeding stools, and scratched and chipped legs of wooden tables and chairs in the second floor dining rooms.

Interview with the maintenance staff confirmed that the floor and the wooden chairs and tables in the dining rooms are not in a good state of repair and the home is in the process of replacing the feeding stools.

On March 18, 2014, the inspector observed in the spa rooms on the second floor that paint was splattered all over the floor, the walls had holes with numerous scrapes and a covering for an electrical outlet was cracked.

Interview with the maintenance staff confirmed that the floors and walls of the spa rooms are in need of repair.

Interview with the ED, who is also the acting lead for maintenance, housekeeping and laundry, confirmed that the scrapes on the floor have been there for at least two years and there are areas of the facility, as well as furnishings that are looking aged and are in need of being replaced and/or repaired. [s. 15. (2) (c)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home 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.

On March 27, 2014, the inspector observed that the call bell cord was wrapped around the pipe below the toilet seat of resident #126's bathroom and the call bell cord was wrapped around the grab bar by the toilet seat of resident #111's and #117's bathrooms.

On March 28, 2014, while resident #117 was sitting in an upright position in bed without staff in attendance, the call bell was observed on the bed side table and could not be easily reached by the resident.

Staff interview confirmed that the call bell cord in the bathrooms should not be wrapped around pipes and grab bars because it prevents them from functioning and should be within easy reach of residents at all times. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance 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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Record review revealed and interview with the registered staff confirmed that resident #84 sometimes complains of pain after receiving routine pain medication but a clinically appropriate assessment instrument for pain has not been used to assess the pain. [s. 52. (2)]

2. Resident #001 was prescribed a medication as needed for pain every four to six hours. Record review and interview with resident #001's SDM revealed that a request was made to the registered staff by the SDM to give resident #001 a medication for his/her pain on identified dates.

Record review revealed and staff interview confirmed that resident #001 complained of pain during an identified period of time, and was given one dose the first two days, four doses the third day and one dose the last two days of treatment.

The home's policy #7.4.1 for Pain Management and PRN Medications revised November 2013 indicates that each resident will be assessed for pain immediately following any report of pain or discomfort, in order to identify the potential cause of the pain/discomfort; and the pain assessment form is to be used for all evaluations.

Interview with registered staff confirmed that resident #001 should have been assessed for pain using a clinically appropriate assessment instrument specifically designed for pain during that period of time, however, this had not been done.

PLEASE NOTE: This evidence of non-compliance was found during inspection #2014_235507-0006. [s. 52. (2)]

3. Record review revealed that resident #003 had a fall on an identified date, was experiencing pain the next two days and was subsequently taken to the hospital for assessment. Record review revealed and registered staff confirmed that the resident was not assessed using a clinically appropriate assessment instrument for pain on the two days after the fall.

PLEASE NOTE: This evidence of non-compliance was found during inspection #2014_321501-0004. [s. 52. (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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

A review of the home's policy 6-18, titled Resident Meal Service revised in March 2013, indicates that residents should be properly positioned at a comfortable height during meals.

A review of the Feeding Techniques and Meal Assistance Manual used to teach staff about proper positioning outlines proper positioning as follows:
1. Resident is to be seated as upright as possible (60-90 degree angle is ideal)
2. Resident's chin should be down and head slightly forward if possible
3. Care giver is to always sit while feeding dependent residents (at or slightly below eye level)
4. Care giver is to sit slightly in front, facing dependent resident for good observation.

On March 18, 2014, the inspector observed resident #301 being fed breakfast in bed. The resident was in a reclined position close to a 60 degree angle, leaning towards the right side, and sliding down with his/her feet hanging over the end of the bed. Interview with the PSW who was feeding the resident indicated that he/she believed the resident was in proper feeding position because the head of the bed was elevated to its maximum.

On March 25, 2014, the inspector observed resident #301 being fed lunch in bed in a reclined position close to a 45 degree angle. The head and end of the bed were elevated. Interview with the PSW who was feeding the resident indicated that he/she believed that the resident was in a proper feeding position and that the position prevented him/her from sliding down.
Record review indicated that resident #301 should be positioned at a 90 degree angle. Interview with registered staff confirmed that resident #301 should be seated close to a 90 degree angle and upright to reduce risk of choking.

On March 14, 2014, the inspector observed that resident #192 was sliding down on his/her wheelchair while being fed lunch with her/his feet hanging over the wheelchair's foot rest. The resident's position was close to a 45 degree angle. When the inspector asked an identified PSW if the resident was in a proper feeding position, the PSW called the registered staff and the two of them repositioned the resident in the wheelchair by lifting the resident up and placing his/her feet on the wheelchair's foot rest. [s. 73. (1) 10.]

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 a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provides direct care to residents receive, as a condition of continuing to have contact with residents, training on how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the Act and the regulation.

Interview with the DOC and record review indicated that only 18.18% of registered nurses, 25.87% of registered practical nurses and 20.45% of personal support workers who provide direct care to residents received training in minimizing restraints in 2013. [s. 76. (7) 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 that all staff who provides direct care to residents received, as a condition of continuing to have contact with residents, training on how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the Act and the regulation, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

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

Interview with registered staff revealed that an analgesic cream was applied on resident #134's different body areas by the PSWs. Record review revealed and staff interview confirmed that this analgesic cream is considered a medication and was not prescribed for resident #134. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes, (a) hand hygiene; (b) modes of infection transmission; (c) cleaning and disinfection practices; and (d) use of personal protective equipment.

Interview with the DOC and record review indicated that only 25% of administration staff, 22.22% of registered nurses, 26.19% of registered practical nurses, 34.39% of personal support workers, 50% of recreation staff, 23.81% of dietary staff and 15% of environmental staff received training in infection prevention and control in 2013. [s. 219. (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 that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes, (a) hand hygiene; (b) modes of infection transmission; (c) cleaning and disinfection practices; and (d) use of personal protective equipment, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in pain management, including pain recognition of specific and non-specific signs of pain.

Staff interview and record review indicated that only 16.67% of registered nurses and 42.86% of registered practical nurses who provide direct care to residents received training in pain management in 2013. [s. 221. (1) 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 that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in pain management, including pain recognition of specific and non-specific signs of pain, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Skin and Wound Management Program has a policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Regulation section 50(2)(b)(iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a RD 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.

Record review indicated that the home's pressure ulcers skin care policy revised July 2013 states that residents with stage III or greater will be referred to the RD. This policy is not in accordance with the regulation that states the RD is to make an assessment of any resident with "altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds" and does not refer to any specific staging of skin breakdown. [s. 8. (1) (a)]

2. The licensee failed to ensure that the medication management system has a drug destruction and disposal policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act. Regulation section 136(4) states that where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause 3(a) to document the following in the drug record:
1. The date of removal of the drug from the drug storage area.
2. The name of the resident for whom the drug was prescribed, where applicable.
3. The prescription number of the drug, where applicable.
4. The drug's name, strength and quantity.
5. The reason for destruction.
6. The date when the drug was destroyed.
7. The names of the members of the team who destroyed the drug.
8. The manner of destruction of the drug.

Record review revealed that the home's policy # 3.14 effective from July 1, 2010, on disposal of surplus medications does not include recording the names of persons who destroyed the drug and the manner of destruction of the drug in the drug record.

Record review revealed and interview with the DOC confirmed that the home's drug destruction record for controlled substance dated August 13, 2013, did not include the

names of persons who destroyed the drug and the manner of destruction of the drug. [s. 8. (1) (a)]

3. The licensee failed to ensure that the home's Disposal of Surplus Medications policy is complied with.

Record review revealed that the home's policy #3.14 effective from July 1, 2010, on disposal of surplus medications states the procedure for the disposal of surplus medications must have two designates to verify the medications to be disposed of against the surplus medication drug form, and both designates must sign the completed forms, date them and seal the box or cylinder for pickup.

Interview with the designated day nurse confirmed that the surplus medication containers and completed surplus medication drug forms are removed from all units by the pharmacist and the designated day nurse during the surplus medication disposal process. The surplus medication that is in individual pouches is placed in a container in the basement storage room and liquid surplus medication is poured into the container to act as a denaturing agent. The designated day nurse confirmed that the verification of medications to be disposed of against the surplus medication drug form is not carried out during the drug disposal process.

On March 21, 2014, the inspector observed a container full of medication in individual pouches with no fluid in the container in the basement storage room. The container was covered by a lid, but not sealed. Interview with staff confirmed that the container with surplus medication was waiting to be picked up by the disposal company, and it should have been sealed. [s. 8. (1) (b)]

4. The licensee failed to ensure that the home's Pain Management and PRN Medications policy is complied with.

The home's policy #7.4.1 for Pain Management and PRN Medications revised November 2013, indicates that pain management will be evaluated quarterly for each resident for effectiveness. Interview with the registered staff confirmed that the clinically appropriate pain assessment instrument should be documented quarterly for each resident but was missed in January 2014 for resident #132. [s. 8. (1) (b)]

5. The licensee of the home failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A review of the home's policy #3.14 titled Advanced Directives found in the Resident Care Manual and revised May 2013 revealed that a discussion relating to resuscitative care preferences of the resident will be initiated with the initial admission care conference and the physician will be given the copy for his/her signature.

Record review revealed and interview with the social worker confirmed that during the admission care conference for resident #1 a discussion relating to resuscitative care preferences was not initiated and the physician did not sign the advanced directives form.

PLEASE NOTE: This evidence of non-compliance was found during inspection #2014_321501-0004. [s. 8. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents.

On March 14, 2013, the inspector observed an unlocked door leading to the clean laundry room on the second floor of the east wing. PSWs and registered staff confirmed that this door should be locked at all times and were not aware that the lock was not in proper working order. The lock on the door was observed fixed March 17, 2014. [s. 9. (1) 2.]

WN #14: 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 failed to immediately report when a person who had reasonable grounds to suspect that any abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Record review and staff interview revealed that the licensee received a report from a family member that an identified resident could have been verbally abused by two identified staff members while providing care on an identified date. Record review and staff interview confirmed that the home conducted an internal investigation and did not report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under the program of nursing and personal support services, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

On March 17, 2014, inspector #501 observed small bruises on resident #94. On March 21, 2014, inspector #507 observed fading bruises on resident #94.

Interview with an identified PSW indicated that he/she noticed a small bruise on resident #94's left hand between his/her thumb and first finger, and reported this to the registered staff the same day during the week of March 10, 2014.

Record review and interviews with nursing staff confirmed that the bruises on resident #94 were not observed or documented, and the report from the PSW related to one of the bruises was not documented.

On March 18, 2014, inspector #501 observed several areas of dried blood on resident #129. On March 20, 2014, inspector #507 observed small dried scabs on resident's body areas.

Interview with an identified PSW indicated that he/she noticed spots of blood on resident #129 on an identified date, and reported this to the registered staff the same day. Record review and interviews with registered staff confirmed that a report from the PSW related to spots of blood on resident #129 was not documented. [s. 30. (2)]

2. Record review revealed that resident #001 was given a medication for pain at 5 pm and 9 pm, and was documented in the 24 hours communication book. However, the administration of the medication and the effectiveness of the medication was not documented.

PLEASE NOTE: This evidence of non-compliance was found during inspection #2014_235507-0006. [s. 30. (2)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that if a resident is restrained by a physical device, the physical device is included in the resident's plan of care.

On March 21, 2014, the inspector observed resident #228 wearing a restraint while sitting in a wheelchair. Record review revealed and staff interview confirmed that the physical device was not included in the resident's plan of care. [s. 31. (1)]

2. The licensee failed to ensure that when a resident is restrained, the physical device is ordered and approved by a physician, registered nurse in the extended class or other person provided for in the regulations.

On March 21, 2014, the inspector observed resident #228 wearing a restraint while sitting in a wheelchair. Interview with the ADOC confirmed that a restraint was also applied on identified dates. Record review revealed and interview with the ADOC confirmed that the resident was wearing the restraint without an order and approval from the physician. [s. 31. (2) 4.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee failed to ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

Record review revealed resident #501 is incontinent, has pressure ulcers and uses a therapeutic surface.

A review of the information on low air loss therapeutic surface provided by the DOC gives directions to never use a sheet on top of the therapy pad and only use a disposal incontinence pad as required for the prevention of friction and shear with the therapy pad.

Interview with staff and the DOC confirmed that items for therapeutic surfaces are not supplied by the home. Record review and family interview confirmed that resident #501's family has been paying for these supplies for the resident. [s. 44.]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (3) The licensee shall assist in the establishment of a Family Council within 30 days of receiving a request from a person mentioned in subsection (2). 2007, c. 8, s. 59. (3).

Findings/Faits saillants :

1. The licensee failed to assist in the establishment of a Family Council within 30 days of receiving a request.

Interview with the DOC revealed that the home currently does not have a Family Council because there are not enough interested family members. Interview with the social worker revealed that during a family information night on January 14, 2014, families were informed that 12-15 members are needed for a Family Council and became aware that there were three to five family members who may be interested. The inspector confirmed through interviews that there are at least three family members interested in participating in a Family Council. The social worker has since been in contact with these family members and is going to assist them in forming a Family Council. [s. 59. (3)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

On March 18, 2014, the inspector observed that certain juices were not available on the second floor of the west wing for breakfast. The daily menu posted indicated that pineapple juice was to be offered and the weekly menu indicated that apple, orange and cranberry juices were also available upon request on a daily basis.

Review of the diet list indicated that resident #173 likes a certain juice. On March 18, 2014, the inspector observed an identified PSW requesting a glass of that specific juice for resident #305. An identified dietary aide stated that the specific juice was not available and the resident was served another type of juice.

Interview with the FSS confirmed that the planned menu items should be available in all serveries and, if any particular menu item runs out, the dietary aide should inform the FSS or call the kitchen or another floor to have the item brought to the servery. [s. 71. (4)]

2. Review of the lunch menu for March 25, 2014, indicated the following menu items were planned for residents on pureed textured diets:
(1) pureed glazed pork chop, gravy, pureed noodles, pureed whole wheat bread, pureed parsnips, and pureed strawberry rhubarb crisp or
(2) pureed roast lamb, mint jelly, mashed potatoes, pureed whole wheat bread, pureed PEI vegetables blend.

On March 25, 2014, the inspector observed that resident #218 received a pureed meal. The resident did not receive certain pureed food items as indicated on the planned menu.

Record review revealed that certain pureed items were not prepared. Interview with the FSS confirmed that certain pureed food items were not available as indicated on the planned menu. [s. 71. (4)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, as part of the organized program of maintenance services, there are schedules and procedures in place for routine, preventive and remedial maintenance.

The home's policy, titled Preventive Maintenance Program, effective February 2013, indicates that there will be an established documented preventive maintenance program and schedule of preventive maintenance procedures for the building system and building contents, all equipment and appliances.

Record review revealed that the home does not have a documented preventive maintenance program and schedule of preventive maintenance procedures for the building system and building contents, all equipment and appliances.

Interview with the ED, who is also the acting designated lead for laundry, housekeeping, and maintenance indicated that he/she believes the home has a preventive program in place but did not provide any documentation to confirm that the home has schedules and procedures in place for routine and preventive maintenance. [s. 90. (1) (b)]

WN #21: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the designated staff member to co-ordinate the infection prevention and control program completed the education in infection prevention and control practices.

Record review and interview with the DOC revealed that she/he is the designated staff member to co-ordinate the infection prevention and control program and is in the process of completing the Non-Acute Care Infection Control Professional Training (NAC ICP). [s. 229. (3)]

Issued on this 12th day of May, 2014

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

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) :	SUSAN SEMEREDY (501), AMANDA WILLIAMS (101), JOELLE TAILLEFER (211), JULIENNE NGONLOGA (502), STELLA NG (507)
Inspection No. / No de l'inspection :	2014_321501_0003
Log No. / Registre no:	T-44-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 9, 2014
Licensee / Titulaire de permis :	THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA 2 OVERLEA BLVD, TORONTO, ON, M4H-1P4
LTC Home / Foyer de SLD :	ISABEL AND ARTHUR MEIGHEN MANOR 155 MILLWOOD ROAD, TORONTO, ON, M4S-1J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DENNIS BROWN

Ontario

Ministry of Health and Long-Term Care

Ministére 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

To THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA s.5 to ensure that the dining areas throughout the home are a safe and secure environment for its residents.

The plan must include strategies to ensure that risks to residents are mitigated in the following dining areas:
-serveries
-dish washing areas
-service elevators.

The plan is to be emailed to susan.semeredy@ontario.ca by May 21, 2014.

Grounds / Motifs :

1. On March 14, 2014, inspector #501 observed that the dining room area on the east wing of the second floor secure unit has two entrances; one entrance had a wander strip across preventing access and the other entrance's wander strip was broken and had a resident in a wheelchair partially blocking the entrance. The floor of the dining room had just been washed and there were no wet floor signs to identify the slip hazard. The inspector entered the dining room and observed that a small wooden set of swinging doors to the servery was unlocked. The inspector was able to gain access to a hot water machine and pour boiling hot water into a cup which had the potential to scald or burn cognitively impaired residents who gained access to this area. At this time, there were no staff members in sight. The inspector also observed from the servery area that there was an unlocked sliding door leading to a dish washing area which had a commercial dishwasher that could potentially cause injury to residents who enabled this piece of equipment. A dietary aide appeared in the

area and stated that the swinging doors are meant to be locked with a wooden bar, however many residents are able to remove this bar. The dietary aide also stated that the lock for the sliding doors to the dish washing area was not working.

On March 14, 2014, inspector #211 observed that the dining room areas on the west wing of the third and fourth floors each have two entrances and these entrances did not have barriers or wander strips to prevent access by residents. The inspector observed that in each dining room there was a set of small wooden swinging doors to the serveries which were open. The inspector was able to gain access to hot water machines which had the potential to scald or burn residents who accessed these areas. At this time, there were no staff members in sight. The inspector also observed from the servery areas that there were unlocked sliding doors leading to dish washing areas and service elevators. The dish washing areas had commercial dishwashers which could cause potential injury to residents who enabled this piece of equipment. On the third floor the service elevator had a key in it which could enable residents to gain further access to non-residential areas. Interview with a dietary aide on the third floor revealed that the lock for the swinging doors does not work because the hatch that holds the wooden bar is broken and confirmed he/she left the key in the elevator. Interview with registered staff on the fourth floor revealed the swinging doors are usually locked with a wooden bar but he/she could not find this bar at the moment.

Interview with the ED confirmed an awareness that the doors to the servery areas were a risk to residents and the home had been looking at different options. (501)

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

Order # / Ordre no : 002

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

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 licensee shall prepare, submit and implement a plan to ensure that all beds with bed rails with identified zones of entrapment are eliminated to ensure resident safety.

The plan shall include immediate, short-term and long-term strategies to eliminate the risks to residents in beds with bedrails.

The plan is to be emailed to Joelle.Taillefer@ontario.ca by May 21, 2014.

Grounds / Motifs :

1. The home had an audit conducted by Shoppers Home Health dated July 15, 2013. The report identified that beds with old-quarter length rails did not pass the Dimensional Test for Bed Systems related to entrapment zones. Recommendations were left for the home to replace all old one-quarter length rails with new ones because of risk for entrapment at zones 2 and 4.

On March 14, 24, and 26, 2014, the inspector observed that the beds in identified resident rooms had old one-quarter length rails. Interview with the DOC on March 26, 2014, revealed that the home has not ensured that all unsafe bed rails have been replaced since the audit of July 15, 2013. (211)

2. The home has not implemented interventions to address the audit report conducted by Shoppers Home Health Care. The ED and DOC provided the following additional information on April 11, 2014, of the 168 beds of the home:
- 154 beds failed the test for zones 2 and 4
- 12 beds with therapeutic surfaces were not tested. (101)

3. The following additional identified resident beds were confirmed to have zones of entrapment by the inspector for zones 2, 3, 4 and 6.
(101)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2014

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 9th day of May, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

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