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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 14, 2014	2014_322156_0018	H-001459-14	Resident Quality Inspection

Licensee/Titulaire de permis

CITY OF HAMILTON
77 James Street North, Suite 400 HAMILTON ON L8R 2K3

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

MACASSA LODGE
701 UPPER SHERMAN AVENUE HAMILTON ON L8V 3M7

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

CAROL POLCZ (156), BERNADETTE SUSNIK (120), CYNTHIA DITOMASSO (528), LISA VINK (168)

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): October 22, 23, 24, 27, 28, 29, 30, 31, 2014

This Inspection Report contains findings of non-compliance identified during inspections conducted concurrently with the Resident Quality Inspection. Concurrent Critical Incident inspection included H-000361-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), registered staff, personal support workers (psw's), Food Services Manager (FSM), Food Service Supervisor (FSS), dietary aides, cooks, Registered Dietitian (RD), Housekeeping and Laundry Supervisor, payroll clerk, Maintenance Supervisor, Therapeutic Recreation staff, maintenance and housekeeping staff, residents and family members.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

- **23 WN(s)**
- **10 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 did not ensure that activation stations connected to the resident-staff communication and response system were made available in every area accessible by residents.

Resident accessible areas within the S section of the building consisted of the hair salon, chapel, auditorium, physiotherapy room, main entrance sitting area, resident's library and special events room. Within the resident living areas located within sections A, C, D and E, activation stations were not made available in common lounges, sitting areas, activity rooms, resident laundry room, dining rooms, balconies and courtyards. Other rooms throughout the home were identified as meeting and conference rooms and found to be accessible to residents (unlocked) without an activation station. According to some staff, the rooms are used for a variety of reasons, not just staff meetings. Should the licensee decide to make the rooms strictly for staff use, the rooms do not require an activation station but will need to be kept inaccessible to residents. [s. 17. (1) (e)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Findings/Faits saillants :

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

The home was built in various stages between 1955 and 1998 and therefore the section of the lighting table that applies is titled "All Other Homes". Measurements were taken of the light fixtures in specific areas throughout the home using a hand held analog illumination meter. Random resident bedrooms, washrooms, tub/shower rooms, activity rooms, common lounges, corridors and dining rooms were measured in the A, C, D and E sections.

The outdoor condition on the day of the test was overcast with sunny periods. Natural light was filtered out as much as possible (blinds/curtains pulled) to mimic night time conditions when lighting levels drop and depend on an artificial source of light. The meter was held level at a standard 30 inches above the floor, out away from the body and towards sources of artificial light. Areas measured included only areas where activities take place and not in corners of rooms, at windows or along walls. Illumination levels quoted are not 100% accurate and have a variance of +/- 10% due to meter type.

Resident Bedrooms

Resident semi-private identified bedroom was equipped with a flush mount ceiling fixture in the centre of each of the two resident spaces. Resident rooms in C and E wings were equipped with the same light fixtures. The lux level under the central light was 160 lux. An over bed light or wall sconce with the majority of the light directed up towards the ceiling was provided in all bedrooms on E wing. The lux was 200 lux.

Resident semi-private identified bedroom was not equipped with any ceiling fixtures, but had 2 wall sconces, 2 over bed lights and two vanity nooks with a small wall mounted light. With all lights on in the room, the general lux was 0-20 lux in and around the resident beds. The over bed light was 230 lux.

The bedrooms are required to have 215.28 lux in and around the bed, wardrobes and other areas where residents would dress, sit or perform activities. The required lux for the over bed light is 376.73 while the bed is in a reading position.

Washrooms

The resident ensuite washroom in an identified room was equipped with a pot light above the toilet area. The lux above the toilet area was 170 lux. The vanity area had a sconce light on either side of the mirror and was adequate at 230 lux.

The resident ensuite washroom in an identified room was equipped with a fluorescent tube light mounted on the ceiling above the vanity. The lux over the vanity was 120 lux and the lux above the toilet area was 20 lux.

A common washroom in the D wing (near servery) was measured to have 20 lux above the vanity area. The common washroom on the opposite end of the corridor was 100 lux

at the toilet area.

A minimum lux of 215.28 is required in and around the vanity and toilet areas.

Lounges

The television lounge and activity room in D wing were both equipped with similar light fixtures. Neither could not be fully measured due to natural light influences. The back end of the both of the rooms (towards the corridor) were measured to be 90-100 lux. The rooms were equipped with small round flush mounted ceiling lights and 2 wall sconces.

The A wing activity rooms were equipped with pot lights for a general lux of 100-180 lux. The area away from the windows was measured, towards the door and under the lower part of the ceiling.

The television lounge in the first floor E wing was equipped with pot and spot lights and recessed tube lights. The lux in some of the room was 150-200.

Lounges and sitting spaces are required to provide a minimum of 215.28 lux.

Corridors

Corridors located in the E and C wings were similarly equipped with a variety of pot lights, spot lights, wall sconces and fluorescent tubes recessed above ceiling areas. The D wing corridor was equipped with hanging globe lights and wall sconces.

Corridors E1 and E2 were measured to be 20-90 lux in certain areas where the recessed tube lights were not provided. The lux centrally down the hall was 100-120 (under pot lights) and 0-20 lux between pot lights. Pot lights were spaced 12 feet apart.

The corridor between C218 and C231 was measured to be 50-100 lux.

The corridor along side of the medication room, documentation room and servery on E2 was 20 lux between and under the pot lights.

The corridor along the D wing between D117 and D110 and D118 and D123 were equipped with wall sconces only. They were spaced 18-28 feet apart. The lux could not

be accurately measured due to high windows in the corridor, however the sconces were not able to provide more than 50 lux of illumination.

All corridors are required to provide a minimum of 215.28 lux that is consistent and continuous along the length of the corridor. [s. 18.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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:
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 did not ensure that all doors leading to stairways and to an unsecured outdoor area were,

iii. equipped with an audible door alarm that allowed the call to be canceled only at the point of activation (at the door), and
A. that the stairwell doors were connected to the resident-staff communication and response system, or
B. connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door.

Numerous stairwell doors to which residents had access were located within the A, E, C, D and S sections of the building. The S section of the building was occupied by administrative offices, kitchen, tuck shop, resident's library, auditorium, physiotherapy room, chapel, hair salon and staff areas. The S section was linked to the A, E, C and D sections which were resident occupied areas. The A, E, C and D sections included a total of 11 home areas and the laundry. All of the stairwell doors were equipped with a door control access system but not an audible door alarm. Several doors were tested by holding the door open for longer than one minute and no alarm sounded. Confirmation was made with the Director of Environmental Services on October 29, 2014, that the doors were not connected to the home's resident-staff communication and response system. The system consisted of a handset console located in the nursing office or at a nursing station in each of the 11 home areas. The handset console is the equivalent of an audio visual enunciator panel. The S section of the building did not have a handset console located anywhere on the main floor.

The main foyer was equipped with sliding glass doors leading to the outside or an unsecured outdoor area. The door was connected to a key pad which released the sliding door to open when a code was entered. The door however was not connected to the resident-staff communication and response system or was equipped with an audible alarm. [s. 9. (1)]

2. The licensee did not ensure that all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, were equipped with locks to restrict unsupervised access to those areas by residents.

Within the S section of the building, in the main entrance foyer, two sets of glass doors were located leading to an enclosed outdoor courtyard. The doors were equipped with a locking mechanism that could easily be unlocked by residents that would allow them to exit the building without staff knowledge (unsupervised). The home's other balcony and courtyard doors were equipped with either a magnetic locking mechanism or a key lock which required staff involvement to unlock and therefore ensuring that they were aware that outdoor space would be in use. Outdoor space used by residents without staff knowledge is of particular concern at night and during cold weather months. [s. 9. (1) 1.1.]

3. The licensee did not ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents.

A laundry chute (1C3) and garbage chute (1C2) room were located on all three floors known as the C section of the building. None of the rooms were equipped with locks to keep residents from accessing the areas. The chutes on floors 2 and 3 pose a safety risk for residents who may fall down into them and the chutes on the bottom floor are a risk should someone step under the chute. Both of these types of spaces are considered non-residential or areas that residents should not be accessing.

The staff wing which included but was not limited to a staff dining room, kitchenette and staff lounge was not restricted in any way to residents. The kitchenette was observed to contain a variety of appliances including a hot water machine, toaster and microwave. A door was available separating the staff wing from the corridor and resident's library space which was situated directly across from the staff wing entrance. The staff wing is considered a non-residential area and was not equipped with any locking mechanisms to restrict unsupervised access to the area. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents., to be implemented voluntarily.

WN #4: 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 did not ensure that the home was a safe environment for its residents.

Dining rooms located in the A section of the building, both on second and third floors were designed such that some servery appliances such as a coffee machine (with a hot water dispenser) and large commercial toaster were located on open counters located within the dining area and accessible to residents. During meal service, hot holding carts would be wheeled into position in front of the counters and staff would be able to access the appliances. The serveries were very small and not able to accommodate the hot holding cart. According to the Food Services Supervisor, the serveries are slated for a minor renovation in mid 2015. The plan was to ensure that all the appliances and hot holding cart would be secured behind a partition of some form and away from resident access. However, until such time, no alternatives had been explored to minimize the potential for residents to burn themselves on any of the appliances once meal service had ended and staff left the room. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home was a safe environment for its residents, to be implemented voluntarily.

WN #5: 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 did not ensure that equipment was maintained in a good state of repair. During the inspection, observations were made that many of the tubs located in the tub rooms did not have any disinfectant products hooked up to the interior lines. Staff working in the various home areas confirmed that they could not hook up the product due to malfunctioning components. Records acquired from the Director of Nursing Services (DNS) confirmed that 7 out of the 12 tubs inspected in February 2013 by an equipment consultant were not fully functional. The licensee had a contract with the tub manufacturer to provide inspection and repair services. The DNS reported that they were made fully aware in early 2013 that tub parts were no longer available for their tubs, all of which were about the same age. The DNS stated that plans were in place for replacing the tubs and that two tubs had already been replaced since February 2013. No time frame to replace the other 5 tubs was provided. [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 equipment was maintained in a good state of repair., to be implemented voluntarily.

WN #6: 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 has failed to ensure that where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

A) On the evening of October 28, 2014, resident #20 was observed to be laying in bed with two standard rails in the raised position. Review of the plan of care did not include a formalized assessment of the resident related to bed rails. Interview with the DOC confirmed that a formalized assessment of the resident related to bed rails was not completed. [s. 15. (1) (a)]

2. The licensee failed to ensure that where bed rails were used, the resident was assessed in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Resident #41 was observed on October 24, 28, and 29, 2014, each time in bed with two quarter rails in the raised position. Staff interviewed confirmed the use of the rails as a need for the resident. A review of the clinical record did not include an assessment of the resident related to the use of the bed rails, as confirmed during an interview with registered staff. (168) [s. 15. (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 where bed rails are used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #7: 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. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(g) any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that if a resident was restrained by a physical device under subsection (1), the licensee ensured that, any other requirements provided for in the regulations were satisfied.

Ontario Regulation 79/10 section 110(1)2 identified that physical devices in use were to be well maintained.

Resident #40 was observed to use a side fastening seat belt on October 23, and 24, 2014. The clinical record confirmed the use of the physical device as a restraint. The belt was not well maintained. The device was observed to be frayed by approximately eight fibers in width and approximately three inches in length across the residents abdomen when fastened. Interview with registered staff on October 24, 2014, confirmed that the belt was frayed and as a result a requisition to have the device replaced was initiated. (168) [s. 31. (3) (g)]

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 if a resident was restrained by a physical device under subsection (1), the licensee ensured that, any other requirements provided for in the regulations were satisfied.
Ontario Regulation 79/10 section 110(1)2 identified that physical devices in use were to be well maintained., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter.
A) The RD confirmed during interview on October 28, 2014 that resident #11 did not have a weight measured or recorded for the month of August, 2014.
B) Front line staff confirmed during interview on October 29, 2014 that resident #21 did not have a weight measured or recorded for the months of March and April, 2014. [s. 68. (2) (e) (i)]

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 was a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status

A)Resident #11 had a weight recorded as 78.5 kg on April 1, 2014 and 74.3 kg on May 2, 2014, which represents a 4.2 kg weight loss in one month or 5.4 per cent over one month. The RD requested that the resident be reweighed as indicated in the progress notes dated May 5, 2014. There was no evidence that the resident was reweighed and the resident was not reassessed as confirmed with the RD on October 28, 2014.
The resident's weight was recorded as 74.5 kg on September 3, 2014 and 60.9 kg on October 5, 2014. The resident was reweighed and the new weight was recoded as 60.5 kg on October 12, 2014. The resident was reweighed on October 16, 2014 and the weight was recorded as 69.1 kg which represents a loss of 5.4 kg or 7.2 per cent over one month. The resident was not reassessed as of October 28, 2014 for the continued weight loss as confirmed with the RD. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. B)Resident #19 had a weight recorded as 71.5 kg on June 7, 2014 and 63.5 kg on July 25, 2014, which represents a 8.0 kg weight loss in one month or 11.2 per cent over one month. There was no evidence that the resident was reweighed and the resident's weight loss was not reassessed as confirmed with the RD on October 28, 2014. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were standardized recipes and production sheets for all menus.
On October 28, 2014, the cook reported that there was no recipe for the minced and pureed textured veal or puree pasta. The cook confirmed that they do not always have standardized recipes. Another cook reported that she added milk and whip cream to slab cake which she pureed to use for pureed cupcake and that she added water to canned rice pudding which she pureed. The cook and FSS confirmed on October 28, 2014 that there were no standardized recipes to follow to ensure consistency of food production. [s. 72. (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 there were standardized recipes and production sheets for all menus, to be implemented voluntarily.

WN #11: 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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
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 has failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
A) Resident #51 was observed in the dining room on October 22, 2014 with the meal on the table in front of them for over ten minutes without any intervention by staff. The resident was woken by staff at approximately 1230 hours and the resident proceeded to eat the meal. The care plan for the resident indicated that the resident required one person to physically assist with meals. The resident was not provided with personal assistance or encouragement required to safely eat and drink as comfortably and as independently as possible.
B) Resident #52 was observed on October 29, 2014 asleep at the table in the dining room from 1245 hours until 1300 hours with one hand in the food and the resident's head

leaned over so it was almost in the plate. Staff did not approach the resident to offer assistance or encouragement for 15 minutes. The resident's care plan indicated that extensive assistance was required with one person to assist. The care plan also indicated that the resident could now feed themselves but required help at times. The resident was not provided with personal assistance or encouragement required to safely eat and drink as comfortably and as independently as possible. [s. 73. (1) 9.]

2. The licensee has failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
A) Resident #50 was observed on October 22, 2014 in bed eating lunch independently, however, the resident was positioned at approximately 45 degrees and tilted to one side. The plan of care for the resident indicated that the resident required one person to assist with eating. The resident was not provided with personal assistance required including positioning to safely eat the meal. [s. 73. (1) 9.]

3. The licensee did not ensure that the home's dining and snack service included proper techniques to assist residents with eating, including safe positioning of residents who required assistance.

A) During dinner service on October 28, 2014, registered staff was observed feeding resident #34, which did not include safe positioning of the resident. The resident was sitting in a broda wheelchair tilted at approximately 30 degrees. The resident was observed to have one episode of coughing while being fed the entree. At the end of the meal the registered staff changed the tilt of the wheelchair sitting the resident at approximately 45 degrees. Review of the plan of care for the resident revealed that the resident was high risk for aspiration due to progressive decline. In April 2014 the resident was assessed by OT and RD related to safe positioning during mealtimes. The OT indicated that the resident could not tolerate a 90 degree position and some recline would be necessary during meals in order to prevent the resident from sliding out of the chair. The RD confirmed that the resident was safe to eat meals in broda chair with a slight tilt activated without sliding out of the chair. Interview with registered staff confirmed that the tilt function on the wheelchair was not released to a safer position for feeding until the end of the meal. [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 residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible and to ensure that the home's dining and snack service included proper techniques to assist residents with eating, including safe positioning of residents who required assistance., to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).
(c) removal and safe disposal of dry and wet garbage; and O. Reg. 79/10, s. 87 (2).
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that equipment was cleaned and disinfected in accordance with manufacturer's specifications and in accordance with prevailing practice.

A disinfectant product (Arjo Disinfectant) was observed to be used undiluted by one worker on a shower chair. The product has a high alkaline pH capable of causing skin and mucous membrane burns when used in the undiluted state. Discussion with 8 personal care workers revealed that the undiluted product was used regularly by pouring it directly from the container onto tub or shower chair surfaces. The product was observed to be stored in most of the home's tub and shower rooms. Instructions on the product label required that it be diluted with water prior to application (8 ml/L). None of the staff who were interviewed reported diluting the product prior to use. The product was diluted only after it was applied onto the equipment (poured or brushed on). Confirmation was made with the Director of Nursing Services and the Arjo consultant that workers had been given in-services on how to use the product and tubs correctly. One worker recalled specifically being informed that the product was never to be hand poured onto the equipment surface full strength.

Tubs located in DW, E1, E2, C3W and C3E did not have a disinfectant product connected to the built-in dispensing line as required. All the tubs were whirlpool tubs except for the tub in C3E which was a hydro sound tub without any internal jet lines. The workers reported that they used the undiluted disinfectant product by hand pouring it out full strength onto the tub surface and scrubbing the product onto the equipment with a brush. The staff described that the tubs did not have the product attached because the disinfection system was not functional. Several staff were able to explain how to disinfect the lines when the system was functional but did not have an alternative method to disinfect the lines manually. The home's Infection Control designate confirmed that manual disinfection procedures were not provided to staff. The manufacturer's instructions for disinfecting the whirlpool jet lines were very specific in that the disinfectant product needed to have full contact with the lines for 10 minutes. In some of the tub models, the tub would be locked out while this process occurred.

Information was acquired by the tub manufacturer (equipment consultant) regarding an alternative method of disinfecting whirlpool lines when the tub disinfection system was not functional. The consultant stated that their whirlpool tubs required disinfectant be injected into their whirlpool jet lines which he stated were 12 inches long. Without a functional disinfection system, staff would need to complete the task manually. The practice described included filling the tub past the inlet to the jet, and manually adding 8

ml of their undiluted disinfectant to every liter of water. The jet would then need to be turned on so that the disinfectant and water could mix and be allowed to sit inside the line for 10 minutes before draining and rinsing. This process was not implemented in the home. [s. 87. (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 equipment was cleaned and disinfected in accordance with manufacturer's specifications and in accordance with prevailing practice, to be implemented voluntarily.

WN #13: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out a the planned care for the resident.

A) On the evening of October 28, 2014, resident #20 was observed to be laying in bed with two standard rails in the raised position. Review of the plan of care did not indicate the resident required the use of bed rails when in bed. Interview with the direct care staff confirmed that the resident required two standard rails when in bed for positioning. Interview with registered staff confirmed the planned care, related to bed rails, was not specified on the written plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the written plan of care for each resident set out the planned care for the resident.

Resident #41 sustained two falls in 2014, both resulting in injury. The resident was observed on October 24, 28, and 29, 2014, each time in bed with two quarter rails in the raised position. Staff interviewed confirmed the use of the rails as a need for the resident. A review of the plan of care did not include the planned care for the resident related to bed rail use, as confirmed during an interview with registered staff. (168) [s. 6. (1) (a)]

3. The licensee failed to ensure that the written plan of care for each resident set out the planned care for the resident.

Observation of resident #19 and staff interview confirmed the use of eye glasses at all times when awake. The Minimum Data Set (MDS) assessment completed September 2, 2014, included that the resident had impaired vision and used glasses. A review of the plan of care did not include the planned care for the resident related to vision patterns, as it did not include the use of glasses, confirmed during an interview with registered staff. [s. 6. (1) (a)]

4. The licensee failed to ensure that the written plan of care for each resident set out the planned care for the resident.

Interviews with resident #11 and staff identified the use of dentures and the need for staff assistance with oral care. The Minimum Data Set (MDS) assessment completed September 2, 2014, included that the resident had "dentures and/or removable bridge".

A review of the plan of care did not include the planned care for the resident related to oral care, as confirmed during an interview with registered staff. [s. 6. (1) (a)]

5. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.
The plan of care for resident #51 indicated that the resident was to be provided with extensive assistance; one person physical assist. On October 22, 27 and 28, 2014, the resident was observed eating independently in her room . Staff reported on October 28, 2104, that the resident eats independently and only requires assistance when tired or on an as needed basis and confirmed that the plan of care was not correct. The plan of care did not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

6. The licensee failed to ensure that the written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident.

The plan of care for resident #17 identified under the focus statement for mobility that a "new tilt wheelchair was in process May 2014". The resident was observed on October 22, 24, and 27, 2014, using a tilt wheelchair in a reclined position. Interview with registered and PSW staff confirmed the use of the device as a Personal Assistance Services Device (PASD) for positioning. A progress note of July 3, 2014, identified that the tilt wheelchair was in place and set up for the resident. The plan of care did not give clear direction to staff providing care, specifically related to the tilt chair, as it did not include that the resident now had the chair or indications for use, as confirmed during an interview with registered staff. [s. 6. (1) (c)]

7. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) In February 2014, the Quarterly Minimum Data Set (MDS) assessment, Section I. Disease Diagnosis for resident #16, coded the resident as having pneumonia. Review of the clinical health record from August 2013, did not include any documentation that the resident had a respiratory infection. Interview with registered staff confirmed the MDS assessment from February 2014, was not consistent with registered nursing staff or physician's notes from that same quarter. [s. 6. (4) (a)]

8. The licensee has failed to ensure that staff and others involved in the different aspects

of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.
A) The MDS assessment section I f) dated March 11, 2014 for resident #22 indicated that the resident had pneumonia. Review of the progress notes for this time period did not indicate that the resident had pneumonia. Interview with staff on October 29, 2014 confirmed that the resident did not have pneumonia at this time and that it was a coding error in MDS. Staff did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other. [s. 6. (4) (a)]

9. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) On October 27, 2014 from 1000 hours, resident #25 was observed to be sitting in their room, at approximately 1200 hours the resident was wheeled to the dining room for lunch service. Review of the plan of care indicated the resident was occasionally incontinent of bladder and directed staff to check at least every two hours for incontinence, before and after meals. Interview with direct care staff after the resident was assisted to the dining room, confirmed the resident was not toileted or checked for incontinence at any time before lunch, between 1000 and 1200 hours. Interview with registered staff indicated that due to resident's decline in cognition, the resident should be checked for incontinence every two hours as outlined in the plan of care. [s. 6. (7)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure any written complaints that have been received concerning the care of a resident or the operation of the home were immediately forwarded to the Director.

A) In April 2014, the home received a written concern from family regarding end of life care provided to a resident; however, the MOHLTC did not have a record of the written concern. Interview with the DOC confirmed that the issue was resolved, but the initial written concern was not forwarded to the Director. [s. 22. (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 has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, were documented.

A) Review of the plan of care for resident #25 indicated that the resident was occasionally incontinent of bladder and directed staff to check for urinary incontinence every two hours, before and after meals; and required one person physical assistance for toileting. The Continence Care and Bowel Management Program directed direct care staff to complete bowel and voiding coding elements in Point of Care. Reviewed POC documentation for thirty days from October 28, 2014, related to activity toileting and continence; toileting and continence was not documented on day shift 26 out of 30 days, on evenings 22 out of 30 days and nights seven out of 30 days. Interview with direct care staff and registered staff confirmed the resident was occasionally incontinent of bladder and either requested toileting or was incontinent more than once per shift. [s. 30. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) On October 25, 2014, nursing home area E2 did not ensure all resident's were bathed as scheduled.

i. The activity of bathing was documented in POC as not occurring for resident #33 and #32 on October 25, 2014.
ii. The activity of bathing was documented completed as a bed bath for resident #31; however, the resident's plan of care indicated that they preferred a shower.

Interview with direct care staff indicated that due to time constraints on October 25, 2014, resident's #33 and #32 did not get their baths; and resident #31 did not get their preference of a shower. Staff also confirmed that the bath/shower(s) were not rescheduled. [s. 33. (1)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD described in subsection (1) that was used to assist a resident with a routine activity of living was included in the residents' plan of care.

A) Throughout the course of the inspection, resident #20 was noted to be seated in a reclining wheelchair during the day. The Occupational Therapist assessment from September 2014, indicated that the resident would be trialing a dynamic tilt wheelchair to facilitate overall positioning and decrease low back pain. Reviewed the documents the home refers to as the care plan and kardex, which did not include the tilt wheelchair. Interview with direct care staff confirmed that the resident sat in the tilt wheelchair daily, and the wheelchair was tilted on the resident's request. Interview with registered staff on October 24, 2014, confirmed that the plan of care was not updated to include use of the tilt wheelchair. [s. 33. (3)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A) In July, August, and October 2014, residents from home area A3 expressed concerns about assistance from staff. Review of the Resident's Council Minutes did not include a written response with 10 days of receiving the concerns. Interview with the Resident Council President and Resident Council Assistant confirmed that the home did not formally respond in writing within 10 days of receiving the concern. [s. 57. (2)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that they responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

A) In June 2014, concerns were discussed at Family Council monthly meetings and brought to the home's attention related to staffing.In June 2014; and additionally in September 2014, related to staffing. Review of the Family Council monthly meeting minutes revealed that a response to the concerns were addressed the following month at the next meeting. Interview with Family Council President and Administration Assistant confirmed that the home was not responding in writing within 10 days of receiving Family Council advice or concerns. [s. 60. (2)]

WN #20: 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 has failed to ensure that planned menu items were offered and available at each meal and snack. The therapeutic menu indicated that pureed corn was to be available on October 22, 2014, however, the pureed corn was not available on home areas C1 East and West as confirmed with the dietary aide staff. The planned menu items were not available. [s. 71. (4)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

A) During initial tour of the home on October 22, 2014, the following rooms were observed unlocked containing hazardous products accessible to resident:

i. Room 1C31 was unlocked on home area C1 West. Two containers of liquid SURE rinse were stored inside the room. Interview with direct care staff confirmed that the door should have been locked.
ii. Room 1E13 was unlocked on home area E1. One four litre container of arjosound hydrosound, one container of glass and multipurpose cleaner, one container of spermicidal hard surface disinefctant, and one container of odor counteractant were stored in the room. Interview with the PSW and housekeeper who indicated that the lock was broken and maintenance had been notified.

Both rooms were observed the following day to be locked and in working order; with hazardous products inaccessible to residents. [s. 91.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident took any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A) Resident #17 had a history of responsive behaviours according to the clinical record. The resident was prescribed medication to assist in the management of the behaviours, which was decreased on April 30, 2014. A review of the clinical record included Point of Care (POC) documentation supporting the presence of behaviours, however did not include documentation, in the progress notes or other tools, identifying the resident's response or the effectiveness of the medication change, as confirmed during an interview with registered staff. (168) [s. 134. (a)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) The home's Policy: IC-02-04:Hand Hygiene, last revised January 2014, outlined four moments during resident care when risk of transmission of infection is the highest and when staff should perform hand hygiene; before initial resident environment contact, before aseptic procedure, after body fluid exposure risk, after resident or resident environment contact.

On October 28, 2014, dinner service was observed on home area D1. From approximately 1710 hours, the dietary aide was observed clearing appetizer dishes and utensils, serving the entrees, and then clearing the entree dishes; depending on the resident's progression through the meal service. At no time during the meal service was the dietary aide who was serving the residents observed preforming hand hygiene with either alcohol-based hand rub or soap and water. Interview with dietary aide, at the end of meal service, confirmed that hand hygiene was not completed. [s. 229. (4)]

Issued on this 5th day of December, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROL POLCZ (156), BERNADETTE SUSNIK (120), CYNTHIA DITOMASSO (528), LISA VINK (168)
Inspection No. / No de l'inspection :	2014_322156_0018
Log No. / Registre no:	H-001459-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 14, 2014
Licensee / Titulaire de permis :	CITY OF HAMILTON 77 James Street North, Suite 400, HAMILTON, ON, L8R-2K3
LTC Home / Foyer de SLD :	MACASSA LODGE 701 UPPER SHERMAN AVENUE, HAMILTON, ON, L8V-3M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	VICKI WOODCOX

To CITY OF HAMILTON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 prepare and submit a plan that describes when and how the activation stations will be installed and connected to the resident-staff communication and response system in resident accessible areas.

The plan shall be submitted to the Inspector by email to: Bernadette.susnik@ontario.ca by December 31, 2014. The plan shall be fully implemented by March 31, 2015 unless otherwise approved. Any requests for extensions to compliance dates shall be forwarded to the Inspector for review.

Grounds / Motifs :

1. The licensee did not ensure that activation stations connected to the resident-staff communication and response system were made available in every area accessible by residents.

Resident accessible areas within the S section of the building consisted of the hair salon, chapel, auditorium, physiotherapy room, main entrance sitting area, resident's library and special events room. Within the resident living areas located within sections A, C, D and E, activation stations were not made available in common lounges, sitting areas, activity rooms, resident laundry room, dining rooms, balconies and courtyards. Other rooms throughout the home were identified as meeting and conference rooms and found to be accessible to residents (unlocked) without an activation station. According to some staff, the rooms are used for a variety of reasons, not just staff meetings. Should the licensee decide to make the rooms strictly for staff use, the rooms do not require an activation station but will need to be kept inaccessible to residents. (120)

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

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

Order / Ordre :

The licensee shall prepare and submit a plan that describes when and how the lighting levels in the home will be modified to meet the requirements set in the lighting table.

The plan shall be submitted to the Inspector by email to: Bernadette.susnik@ontario.ca by January 31, 2015. The plan shall be fully implemented by December 31, 2016 unless otherwise approved. Any requests for extensions to compliance dates shall be forwarded to the Inspector for review.

Grounds / Motifs :

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

The home was built in various stages between 1955 and 1998 and therefore the section of the lighting table that applies is titled "All Other Homes". Measurements were taken of the light fixtures in specific areas throughout the home using a hand held analog illumination meter. Random resident bedrooms, washrooms, tub/shower rooms, activity rooms, common lounges, corridors and dining rooms were measured in the A, C, D and E sections.

The outdoor condition on the day of the test was overcast with sunny periods. Natural light was filtered out as much as possible (blinds/curtains pulled) to mimic night time conditions when lighting levels drop and depend on an artificial source of light. The meter was held level at a standard 30 inches above the floor, out away from the body and towards sources of artificial light. Areas measured included only areas where activities take place and not in corners of rooms, at windows or along walls. Illumination levels quoted are not 100% accurate and have a variance of +/- 10% due to meter type.

Resident Bedrooms

Resident semi-private identified bedroom was equipped with a flush mount ceiling fixture in the centre of each of the two resident spaces. Resident rooms in C and E wings were equipped with the same light fixtures. The lux level under the central light was 160 lux. An over bed light or wall sconce with the majority of the light directed up towards the ceiling was provided in all bedrooms on E wing. The lux was 200 lux.

Resident semi-private identified bedroom was not equipped with any ceiling fixtures, but had 2 wall sconces, 2 over bed lights and two vanity nooks with a small wall mounted light. With all lights on in the room, the general lux was 0-20 lux in and around the resident beds. The over bed light was 230 lux.

The bedrooms are required to have 215.28 lux in and around the bed, wardrobes and other areas where residents would dress, sit or perform activities. The required lux for the over bed light is 376.73 while the bed is in a reading position.

Washrooms

The resident ensuite washroom in an identified room was equipped with a pot light above the toilet area. The lux above the toilet area was 170 lux. The vanity area had a sconce light on either side of the mirror and was adequate at 230 lux.

The resident ensuite washroom in an identified room was equipped with a fluorescent tube light mounted on the ceiling above the vanity. The lux over the vanity was 120 lux and the lux above the toilet area was 20 lux.

A common washroom in the D wing (near servery) was measured to have 20 lux above the vanity area. The common washroom on the opposite end of the corridor was 100 lux at the toilet area.

A minimum lux of 215.28 is required in and around the vanity and toilet areas.

Lounges

The television lounge and activity room in D wing were both equipped with similar light fixtures. Neither could not be fully measured due to natural light influences. The back end of the both of the rooms (towards the corridor) were measured to be 90-100 lux. The rooms were equipped with small round flush mounted ceiling lights and 2 wall sconces.

The A wing activity rooms were equipped with pot lights for a general lux of 100-180 lux. The area away from the windows was measured, towards the door and

under the lower part of the ceiling.

The television lounge in the first floor E wing was equipped with pot and spot lights and recessed tube lights. The lux in some of the room was 150-200.

Lounges and sitting spaces are required to provide a minimum of 215.28 lux.

Corridors

Corridors located in the E and C wings were similarly equipped with a variety of pot lights, spot lights, wall sconces and fluorescent tubes recessed above ceiling areas. The D wing corridor was equipped with hanging globe lights and wall sconces.

Corridors E1 and E2 were measured to be 20-90 lux in certain areas where the recessed tube lights were not provided. The lux centrally down the hall was 100 -120 (under pot lights) and 0-20 lux between pot lights. Pot lights were spaced 12 feet apart.

The corridor between C218 and C231 was measured to be 50-100 lux.

The corridor along side of the medication room, documentation room and servery on E2 was 20 lux between and under the pot lights.

The corridor along the D wing between D117 and D110 and D118 and D123 were equipped with wall sconces only. They were spaced 18-28 feet apart. The lux could not be accurately measured due to high windows in the corridor, however the sconces were not able to provide more than 50 lux of illumination.

All corridors are required to provide a minimum of 215.28 lux that is consistent and continuous along the length of the corridor. (120)

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

Order # / Ordre no : 003

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

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 prepare and submit a plan that describes when and how the stairwell doors and main entrance door identified in the grounds below will be equipped with door alarms and connected to the resident-staff communication and response system.

The plan shall be submitted to the Inspector by email to: Bernadette.susnik@ontario.ca by December 31, 2014. The plan shall be fully implemented by March 31, 2015 unless otherwise approved. Any requests for extensions to compliance dates shall be forwarded to the Inspector for review.

Grounds / Motifs :

1. The licensee did not ensure that all doors leading to stairways and to an unsecured outdoor area were,

iii. equipped with an audible door alarm that allowed the call to be canceled only at the point of activation (at the door), and
A. that the stairwell doors were connected to the resident-staff communication and response system, or
B. connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door.

Numerous stairwell doors to which residents had access were located within the A, E, C, D and S sections of the building. The S section of the building was occupied by administrative offices, kitchen, tuck shop, resident's library, auditorium, physiotherapy room, chapel, hair salon and staff areas. The S section was linked to the A, E, C and D sections which were resident occupied areas. The A, E, C and D sections included a total of 11 home areas and the laundry. All of the stairwell doors were equipped with a door control access system but not an audible door alarm. Several doors were tested by holding the door open for longer than one minute and no alarm sounded. Confirmation was made with the Director of Environmental Services on October 29, 2014, that the doors were not connected to the home's resident-staff communication and response system. The system consisted of a handset console located in the nursing office or at a nursing station in each of the 11 home areas. The handset console is the equivalent of an audio visual enunciator panel. The S section of the building did not have a handset console located anywhere on the main floor.

The main foyer was equipped with sliding glass doors leading to the outside or an unsecured outdoor area. The door was connected to a key pad which released the sliding door to open when a code was entered. The door however was not connected to the resident-staff communication and response system or was equipped with an audible alarm.
(120)

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

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

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 14th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROL POLCZ

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