Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 27, 2015	2015_269597_0002	T-000071-14	Resident Quality Inspection

Licensee/Titulaire de permis

341822 ONTARIO INC
28 HALTON STREET TORONTO ON M6J 1R3

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

MAYNARD NURSING HOME
28 HALTON STREET TORONTO ON M6J 1R3

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

BEVERLEY GELLERT (597), DEBBIE WARPULA (577), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 19 - 30, 2015

Additional Logs completed concurrently with the RQI:
T-000794-14
T-000218-14
T-000597-14
T-000742-13
T-001327-14
T-001528-14

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Life Enrichment Coordinator, Maintenance Worker, Housekeeping Aide

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
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

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

- **17 WN(s)**
- **6 VPC(s)**
- **4 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 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. (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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Inspector #577 interviewed Resident #021, who reported that they have to wait too long for assistance to use the commode.

Inspector #577 conducted a record review of this resident's care plan. The interventions related to toileting include that the resident will call for help when they require assistance to the commode, yet under the nursing focus of bladder function, the care plan indicates that the commode has been removed as resident is at risk of falling. [s. 6. (1) (c)]

2. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Resident #021 informed Inspector #577 that they have dental problems and prefer not to

wear dentures. Inspector #577 reviewed the resident's care plan which indicates that staff must ensure that the resident receives assistance with dentures yet under the focus of Nutrition problems, the care plan indicates that the resident does not wear their dentures.

Staff interviewed by inspector confirmed that the resident does not wear their dentures. [s. 6. (1) (c)]

3. The licensee has failed to ensure that there is a written plan of care for each resident that sets out (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Resident #026 suffered a fall with an injury in 2014. The care plan was reviewed by Inspector #577 who found that it indicated contradictory information on how the resident's mobility should be managed after their injury.

4. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to Resident #005.

The Care Plan for Resident #005 indicates that the following interventions are in place for toileting; no toileting required, uses incontinent products, unsafe to toilet, needs weight bearing support by one to two staff to change brief but most of the time needs one person and unsafe to toilet and needs to stay in bed when changing brief.

The care plan for this resident lists these interventions under the nursing focus of transferring; two staff to transfer with mechanical lift / ceiling lift for all transfers.

Staff interviews confirm that the resident is unsafe to stand.

The care plan for Resident #005 failed to provide clear instruction for staff specifically regarding how to safely manage continence care needs. [s. 6. (1) (c)]

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

Resident #028 was observed lying in bed and the call bell was not within reach yet the current care plan was reviewed and under the focus of; Risk for falls the intervention of call bell within reach when in bed, is included.[s. 6. (1) (c)]

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

Resident #013 sustained a fall with injury in 2014. The care plan that was in effect at the time of the incident included the focus of transferring with the intervention of; provide two staff for extensive assistance from bed to wheelchair and resident to be manually lifted by two staff. At the time of the incident the resident was being assisted to transfer by only one staff.

Resident #013 was not provided with a two person transfer assist as per their plan of care. [s. 6. (7)]

7. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

Resident #026 was interviewed by Inspector #196 and described an incident in which they were injured by another resident.

The care plan of the other resident was reviewed and many interventions related to responsive behaviors were listed.

Despite these interventions, this resident continues to display responsive behaviors. This resident's plan of care has not been reviewed and revised when the care set out in the plan has not been effective. [s. 6. (10) (c)]

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 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 (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).

An anonymous complaint via the Infoline system was received by the Ministry of Health and Long-Term Care (MOHLTC), regarding concerns about the cleanliness of the home and pest control.

Inspector #577 made observations of disrepair in residents' rooms and bathrooms as follows:

- Bathroom - brown water damage around toilet flooring
- Bathroom -wall surface at entry way in disrepair, paneling removed from wall near floor level, silicone surrounding sink water damaged, and sink was loose. Inspector #577 was able to lift sink up.
- Bathroom – lingering odour of urine
- Bathroom – sticky floor
- Resident room – water damage to ceiling tiles
- Resident room - flooring beside bed is old, uneven and worn down.
- Resident room - side rails soiled and dusty
- Resident room - feces on the outside of the toilet bowl in resident shared washroom - staining along the baseboard in the resident's room - tile grout stained extensively in shared washroom
- Resident room - water stains below sink in shared washroom, floor tile grout grossly stained
- Resident room - caulking around sink stained
- Resident room - shared resident washroom base of toilet soiled, dry yellow - floor tile

grout grossly stained and had a buildup of soiling along edges of floor tiles in washroom, buildup of soil along plywood baseboards around the room, piece of clothing, tissue and dirt debris was noted under clothes dresser at the entry to the shared washroom
- Resident room - flooring stained at edge of baseboard - privacy curtains soiled and stained - stains on floor within room - feces and urine were observed on the outside of the toilet bowl, floor tile grout is grossly stained, sink faucet has buildup of debris on it
- Resident room - floor tiles stained in grout and at edges, flooring around the resident room is stained
Resident Room - staining along the baseboard in the resident's room, tile grout stained extensively in shared washroom and brown coloured water damage around toilet flooring in bathroom
- Resident room - washroom floor tile grout grossly stained, water stains below sink, caulking around sink on wall cracked
- Resident room - caulking around washroom sink stained
- Resident room - shared washroom of resident has corroded sink faucet, floor tile grout grossly stained, ply wood base boards unpainted in the resident room, corner wood edge wall by a closet is broken, vinyl type cover on baseboard heater broken away, wall at head has drywall chipped away, soft to touch with black/grey staining
- Resident room - baseboard piece missing, piece of wallboard lifting away from the wall under desk, floor tile grout is grossly stained, sink faucet has buildup on it - drywall has gouges in it above bed
- Resident room - shared washroom sink faucet corroded, floor tiles stained in grout and at edges, caulking around sink stained, dry wall chipped at area of desk, baseboard in room is unpainted plywood
- Resident room - shared washroom sink faucet corroded, floor tiles stained in grout and at edges, caulking around sink stained, flooring around the resident room is stained
- Resident room - bedside table top surface worn at edges, unpainted plywood baseboards in room
Resident room - caulking along base of toilet stained, floor tile grout stained, peeling paint and drywall behind toilet, sink movable and caulking cracked, faucet corroded, piece of baseboard missing in resident room
- Resident room - sharp edge around door
Care units:
- Dusty baseboards in hallway
- Shower room has stained tiles on the floor, grout grossly stained dark brown/black colour
- Tub room - grout stains extensive on tile
- Flooring in the corridor is stained at edges of baseboard

- Shower room toilet bowl dirty and urine was on the toilet seat, sink caulking stained, shower tiles had stained grout in several areas black/brown coloured
- Shower/tub room sink has stained tiles in the shower room
- Dining room window screens were grossly soiled with dead flies, flooring edges of baseboard were stained
- Bed - bed side rail dirty
- Bed - bilateral full side rails soiled in numerous areas
- Baseboard heater loose from the wall, flooring in the corridor is stained at edges of baseboard, sharp edges around the doorway
- Chairs across from nursing desk have ripped vinyl on seating surfaces and arm rests
- Shower room/washroom caulking around sink stained extensively, shower tile grout stained in numerous areas black/brown coloured, rust around grab bar in the shower
- Shower/tub room sink has stained caulking, stained tiles in the shower room, dry wall chipped on the wall, stained ceiling tile

Inspector #577 spoke with #S-101, who reports an unclean working environment for the past 4 years, specifically has observed urine on floors in resident rooms and bathrooms, and strong urine odors in resident bathrooms and shower rooms. [s. 15. (2) (a)]

An interview was conducted with #S-111 regarding the maintenance program in the home. They reported that the maintenance department has not had a full time employee for approximately six months as a result of staffing issues. They also reported that over the past year, resident repairs have been done, for example changing light bulbs, call bell and furniture repairs, but that there has not been remedial maintenance done in the home.[s. 15. (2) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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, (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; O. Reg. 79/10, s. 15 (1).

Inspector #577 interviewed the Administrator and the DOC, who both reported that a contracted company performs the annual entrapment audit of beds in the home.

Inspector #577 met with representative from the contracted company, who reported that the most recent visual inspection of beds in the home, confirmed that 38% of the beds and mattresses in the home have failed to meet the recommendations of Health Canada. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Inspector #577 interviewed Resident #021 who described an incident where they rang the call bell for toileting assistance was told to "just use their diaper" by staff.

The resident described sitting in feces for 3 hours and when staff cleaned the resident, they were not gentle with the resident's arms, during turning. Although this resident reported that some of the staff are not gentle with care and lack compassion.

Inspector #577 conducted a record review of Resident #021's care plan which indicates that the resident will ask for and receive the necessary assistance for toileting.

2. The licensee has failed to ensure that they fully respected and promoted the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Inspector #196 interviewed Resident #026, who reported that staff often speak to them like they are irritated and when they ask for help to go to the washroom and that when staff are busy they will tell this resident to go in their bed or in their "diaper".

#S-102 reported that they are aware of these incidents and have brought it to the attention of the PSW taking care of that resident, and if not available, to the registered staff. The specific incidents had not been reported to the DOC.

An interview was conducted with the DOC and they reported that another manager had told them that there have been issues with night shift staff in which they have told residents to use the diapers instead of taking them to the washroom or toileting them. The DOC stated that this was discussed at a general nursing meeting, registered and non-registered staff, housekeeping and laundry and there was a generalized discussion with the staff regarding abuse and neglect of residents. [s. 3. (1) 4.]

3. The licensee failed to ensure that the following rights of residents are fully respected and promoted: 19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Inspector #577 interviewed #S-103 who reported that they have observed staff force some residents out of bed in the morning. #S-103 reported they have heard staff tell residents, "No you have to get up, its breakfast time". It was further reported that they have observed this several times for many years and that staff have said that the Ministry says they have to get up for breakfast. [s. 3. (1) 19.]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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, (b) is complied with.

The health care record for Resident #013 was reviewed. The progress notes online identify an incident in which the resident had a fall and sustained an injury that required transfer to hospital.

The homes investigation determined that the resident had not been immediately assessed after the fall and was assisted off the shower room floor by three staff. A few hours later, when the injury became apparent, the incident was reported to the DOC.

The licensee's policy/procedure titled "Falls Prevention and Management" states that staff should retain the resident in fall position to await assessment by Registered Staff member.

The licensee's policy was not complied with, specifically when, Resident #013 was moved out of the fall position and was not assessed by the registered staff until approximately three hours after the incident in which the fall occurred.[s.8.(1)(a), s.8.(1)(b)]
2. The licensee has failed to ensure that 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 (b) is complied with.

An interview was conducted with #S-112 regarding the application of topical prescription medication to residents in the home.
Staff reported to the inspector that non-registered staff apply prescription creams / ointments to residents.

It was reported by the DOC that non-registered staff do not administer or apply prescription topical medication to residents and therefore no training is provided to PSWs in this regard. The home's policy states that prescription creams and ointments are applied by registered staff only. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy related to the application of prescription cream and ointments to all other residents is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules are complied with: 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.

During the inspection it was observed that a non-residential area was accessible to residents and had a sign on the door that read "restricted". This is not a resident care area or an area where residents would normally receive care.

An interview was conducted with #S-110 and they reported that this door, leading to non-residential areas, is opened by staff at approximately 0600 hrs, closed and locked at 2000 hrs and it is not supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).

Inspector #577 observed in three resident bathrooms, that the call bell was not easily accessed by residents. In all three bathrooms the call bell was placed high on bathroom wall, and not horizontal to toilet. [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, (a) can be easily seen, accessed and used by residents, staff and visitors at all times specifically in the bathrooms of Residents #022, #024 and #025 and all other residents., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents, specifically Resident #004, was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A Critical Incident was submitted to the Ministry of Health and Long Term Care in relation to staff to resident verbal / physical abuse.

The report described an incident that occurred in 2014 in which #S-115 was verbally and physically abusive toward a resident.

The incident was investigated by the home and the staff member was found to be deserving of disciplinary action.[s. 19. (1)]

2. The licensee has failed to ensure that specifically Resident #007 was protected from abuse by anyone and free from neglect by the licensee or staff in the home

A Critical Incident was submitted to the Ministry of Health and Long Term Care in relation to staff to resident verbal / physical abuse.

The report described an incident that occurred in 2014 in which #S-117 was verbally abusive toward a resident.

The incident was investigated by the home and found the staff to be deserving of disciplinary action.[s. 19. (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 Residents #004 and #007 and all other residents, are protected from abuse by anyone and that residents are not neglected by the licensee or staff, 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 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.

Resident #025 was found to have a significant weight loss following their admission to the home in 2014

An assessment using an interdisciplinary approach was not completed and actions not taken for Resident #025 who suffered significant. [s. 69. 1.,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 Resident #025 and all other 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. 4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #10: 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).

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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to, as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

On several occasions, Inspector #597 noted a lingering urine odour in a hallway and in a resident's room.

2. The licensee has failed to ensure that 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.

Brown stains were noted on the privacy curtain in a resident's room. The stains were unchanged after 9 days. [s. 87. (2)]

3. The licensee has failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures are developed and implemented for, (d) addressing incidents of lingering offensive odours.

During the inspection, a strong odour of urine was noted upon entry to the first floor. An air freshener, with the compartment door open and a red light flashing, was observed on the wall by the stairway leading to the second floor of the home. This strong odour of urine was noted again in the same area of the home two days later.

An interview was conducted with #S-119 and it was reported that a solution is mixed with water and it is sprayed where there is an odour and there are air fresheners throughout the home but #S-119 was not sure what was going on with the one by the stairwell, when questioned.

Maintenance person #S-111, was shown the air freshener with the compartment door open and a red light flashing, and he reported that a canister needed to be replaced.

The licensee's policy titled "air fresheners" dated June 2007, #HSM-C-65 was reviewed. The policy outlined the use of air fresheners in the home to "produce a pleasant atmosphere for residents by eliminating obnoxious odours" and "the Maintenance Supervisor ensures air fresheners are in working order, replacing canisters of air freshener when empty." [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for cleaning of the home, including,privacy curtains and for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents receive individualized personal care, including hygiene care and grooming on a daily basis specifically Resident #004.

Inspector #597 observed a resident to be unshaven on several occasions.

Staff reported that this resident requires one person assistance with all ADLs. Resident is assisted with shaving every other day.

The care plan for this resident indicates that they require assistance to maintain appearance including comb hair, shave, wash and dry face hands and perineum on a daily basis.

The home has failed to ensure that this resident receives assistance with the personal care and grooming he requires on a daily basis. [s. 32.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

It was documented that Resident #021 suffered a fall without injury in 2014.

Inspector interviewed staff, who reported that an electronic post-fall assessment is required to be completed after a resident falls. Upon record review, Inspector #577 found that the post-fall assessment was not completed for the resident after their fall.[s. 49. (2)]

WN #13: 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. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that if there is no Family Council, the licensee shall, (a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and (b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Inspector #577 spoke with #S-102. They reported that there isn't a Family Council or a Council President in the home at present and the last meeting was in March 2013. It was further reported that information about the Family Council is written in a monthly newsletter to residents and families, a memo is posted on a Resident Information board on the first and second floor and also at the front entrance of the home.

Inspector #577 made observations of the memo posted on the Resident Information board's and Family Information board with description of Family Council and request for family members to join.

#S-102 reported that no residents or families have requested a Council. They further reported that the home does not convene semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results.

An interview was conducted with #S-110 regarding the Residents' Council involvement in the development of the satisfaction survey. #S-110 reported that the results are shared with the Residents' Council but they do not have any involvement in the development of the resident satisfaction survey. [s. 85. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

The health care record for resident #013 was reviewed. The progress notes online identify an incident in which the resident had a fall with an injury that required transfer to hospital.

An interview was conducted with the DOC and it was reported that the injury with transfer to hospital was not reported to the Director as there was no significant change to the resident's health status.

The care plan for the resident was reviewed and it was noted that revisions were made to the care plan after the resident returned from hospital

These revisions to the plan of care for Resident #013 identified "significant change" to their health condition requiring informing the Director no later that one business day after the occurrence. [s. 107. (3) 4.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) drugs are stored in an area or a medication cart, (ii) that is secure and locked.

The inspector was shown a plastic bin in an upright cabinet in the nursing office which contained prescription topical medications and government stock barriere creams. The door to the nursing office was unlocked and there were no staff in the area. The Charge Nurse, #S-114 was informed that this door was left unlocked. [s. 129. (1) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to ensure the security of the drug supply, including the following: 2. Access to these areas shall be restricted to, i. persons who may dispense, prescribe or administer drugs in the home, and ii. the Administrator

An interview was conducted with the DOC and it was reported that the maintenance person #S-111 has keys to the medication room and to the government stock medication room.

#S-111, confirmed to the inspector that they had keys to access the medication rooms on each of the units and for the government stock medication room in the basement of the home. They showed the inspector the keys and opened the government stock medication room to show the inspector. [s. 130. 2.]

Issued on this 27th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BEVERLEY GELLERT (597), DEBBIE WARPULA (577), LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2015_269597_0002
Log No. / Registre no:	T-000071-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 27, 2015
Licensee / Titulaire de permis :	341822 ONTARIO INC 28 HALTON STREET, TORONTO, ON, M6J-1R3
LTC Home / Foyer de SLD :	MAYNARD NURSING HOME 28 HALTON STREET, TORONTO, ON, M6J-1R3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Leean Bowman

To 341822 ONTARIO INC, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to Residents #005, #021 and #026 and all other residents. 2007, c. 8, s. 6 (1).

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to Resident #005.

The Care Plan for Resident #005 indicates that the following interventions are in place for toileting; no toileting required, uses incontinent products, unsafe to toilet, needs weight bearing support by one to two staff to change brief but most of the time needs one person and unsafe to toilet and needs to stay in bed when changing brief.

The care plan for this resident lists these interventions under the nursing focus of transferring; two staff to transfer with mechanical lift / ceiling lift for all transfers.

Staff interviews confirm that the resident is unsafe to stand.

The care plan for Resident #005 failed to provide clear instruction for staff specifically regarding how to safely manage continence care needs. [s. 6. (1) (c)] (597)

2. The licensee has failed to ensure that there is a written plan of care for each resident that sets out (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Resident #026 suffered a fall with an injury in 2014. The care plan was reviewed by Inspector #577 who found that it indicated contradictory information on how the resident's mobility should be managed after their injury. [s. 6.(1)]
(577)

3. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Resident #021 informed Inspector #577 that they have dental problems and prefer not to wear dentures. Inspector #577 reviewed the resident's care plan which indicates that staff must ensure that the resident receives assistance with dentures yet under the focus of Nutrition problems, the care plan indicates that the resident does not wear their dentures.

Staff interviewed by inspector confirmed that the resident does not wear their dentures. [s. 6. (1) (c)]
(577)

4. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Inspector #577 interviewed Resident #021, who reported that they have to wait too long for assistance to use the commode.

Inspector #577 conducted a record review of this resident's care plan. The interventions related to toileting include that the resident will call for help when they require assistance to the commode, yet under the nursing focus of bladder function, the care plan indicates that the commode has been removed as resident is at risk of falling. [s. 6. (1) (c)]
(577)

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

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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

Every licensee of a long-term care home shall ensure that, (a) the home, furnishings and equipment are kept clean and sanitary and (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)

Grounds / Motifs :

1. The licensee failed to ensure that (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).

Inspector #577 spoke with #S-101, who reports an unclean working environment for the past 4 years, specifically has observed urine on floors in resident rooms and bathrooms, and strong urine odors in resident bathrooms and shower rooms. [s. 15. (2) (a)]

An interview was conducted with #S-111 regarding the maintenance program in the home. They reported that the maintenance department has not had a full time employee for approximately six months as a result of staffing issues. They also reported that over the past year, resident repairs have been done, for example changing light bulbs, call bell and furniture repairs, but that there has not been remedial maintenance done in the home.[s. 15. (2) (a)] (577)

2. The licensee failed to ensure that (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).

The following observations were made in the general care areas:

- Dusty baseboards in hallway
- Shower room has stained tiles on the floor, grout grossly stained dark brown/black colour
- Tub room - grout stains extensive on tile
- Flooring in the corridor is stained at edges of baseboard
- Shower room toilet bowl dirty and urine was on the toilet seat, sink caulking stained, shower tiles had stained grout in several areas black/brown coloured
- Shower/tub room sink has stained tiles in the shower room
- Dining room window screens were grossly soiled with dead flies, flooring edges of baseboard were stained
- Bed - bed side rail dirty
- Bed - bilateral full side rails soiled in numerous areas
- Baseboard heater loose from the wall, flooring in the corridor is stained at edges of baseboard, sharp edges around the doorway
- Chairs across from nursing desk have ripped vinyl on seating surfaces and arm rests
- Shower room/washroom caulking around sink stained extensively, shower tile grout stained in numerous areas black/brown coloured, rust around grab bar in the shower
- Shower/tub room sink has stained caulking, stained tiles in the shower room, dry wall chipped on the wall, stained ceiling tile[s. 15. (2) (a)]

(577)

3. The licensee failed to ensure that (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).

An anonymous complaint via the Infoline system was received by the Ministry of Health and Long-Term Care (MOHLTC), regarding concerns about the cleanliness of the home and pest control.

Inspector #577 made observations of disrepair in residents' rooms and

bathrooms as follows:

- Bathroom - brown water damage around toilet flooring
- Bathroom -wall surface at entry way in disrepair, paneling removed from wall near floor level, silicone surrounding sink water damaged, and sink was loose. Inspector #577 was able to lift sink up.
- Bathroom – lingering odour of urine
- Bathroom – sticky floor
- Resident room – water damage to ceiling tiles
- Resident room - flooring beside bed is old, uneven and worn down.
- Resident room - side rails soiled and dusty
- Resident room - feces on the outside of the toilet bowl in resident shared washroom - staining along the baseboard in the resident's room - tile grout stained extensively in shared washroom
- Resident room - water stains below sink in shared washroom, floor tile grout grossly stained
- Resident room - caulking around sink stained
- Resident room - shared resident washroom base of toilet soiled, dry yellow - floor tile grout grossly stained and had a buildup of soiling along edges of floor tiles in washroom, buildup of soil along plywood baseboards around the room, piece of clothing, tissue and dirt debris was noted under clothes dresser at the entry to the shared washroom
- Resident room - flooring stained at edge of baseboard - privacy curtains soiled and stained - stains on floor within room - feces and urine were observed on the outside of the toilet bowl, floor tile grout is grossly stained, sink faucet has buildup of debris on it
- Resident room - floor tiles stained in grout and at edges, flooring around the resident room is stained

Resident Room - staining along the baseboard in the resident's room, tile grout stained extensively in shared washroom and brown coloured water damage around toilet flooring in bathroom

- Resident room - washroom floor tile grout grossly stained, water stains below sink, caulking around sink on wall cracked
- Resident room - caulking around washroom sink stained
- Resident room - shared washroom of resident has corroded sink faucet, floor tile grout grossly stained, ply wood base boards unpainted in the resident room, corner wood edge wall by a closet is broken, vinyl type cover on baseboard heater broken away, wall at head has drywall chipped away, soft to touch with black/grey staining

- Resident room - baseboard piece missing, piece of wallboard lifting away from the wall under desk, floor tile grout is grossly stained, sink faucet has buildup on it - drywall has gouges in it above bed
- Resident room - shared washroom sink faucet corroded, floor tiles stained in grout and at edges, caulking around sink stained, dry wall chipped at area of desk, baseboard in room is unpainted plywood
- Resident room - shared washroom sink faucet corroded, floor tiles stained in grout and at edges, caulking around sink stained, flooring around the resident room is stained
- Resident room - bedside table top surface worn at edges, unpainted plywood baseboards in room

Resident room - caulking along base of toilet stained, floor tile grout stained, peeling paint and drywall behind toilet, sink movable and caulking cracked, faucet corroded, piece of baseboard missing in resident room
- Resident room - sharp edge around door[s. 15. (2) (a)]

(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 10, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 :

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 O. Reg. 79/10, s. 15 (1).

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; O. Reg. 79/10, s. 15 (1).

Inspector #577 interviewed the Administrator and the DOC, who both reported that a contracted company performs the annual entrapment audit of beds in the home.

Inspector #577 met with representative from the contracted company, who reported that the most recent visual inspection of beds in the home, confirmed that 38% of the beds and mattresses in the home have failed to meet the recommendations of Health Canada. [s. 15. (1) (b)]
(577)

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted, related to Residents #021 and #026 and all other residents' right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (4).

Grounds / Motifs :

1. The licensee has failed to ensure that they fully respected and promoted the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Inspector #196 interviewed Resident #026, who reported that staff often speak to them like they are irritated and when they ask for help to go to the washroom and that when staff are busy they will tell this resident to go in their bed or in their "diaper".

#S-102 reported that they are aware of these incidents and have brought it to the attention of the PSW taking care of that resident, and if not available, to the registered staff. The specific incidents had not been reported to the DOC.

An interview was conducted with the DOC and they reported that another manager had told them that there have been issues with night shift staff in which they have told residents to use the diapers instead of taking them to the washroom or toileting them. The DOC stated that this was discussed at a general nursing meeting, registered and non-registered staff, housekeeping and

laundry and there was a generalized discussion with the staff regarding abuse and neglect of residents. [s. 3. (1) 4.]
(597)

2. The licensee has failed to fully respect and promote the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Inspector #577 interviewed Resident #021 who described an incident where they rang the call bell for toileting assistance was told to "just use their diaper" by staff.

The resident described sitting in feces for 3 hours and when staff cleaned the resident, they were not gentle with the resident's arms, during turning. Although this resident reported that some of the staff are not gentle with care and lack compassion.

Inspector #577 conducted a record review of Resident #021's care plan which indicates that the resident will ask for and receive the necessary assistance for toileting. [s.3. (1) 4]

(597)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 27th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Beverley Gellert

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