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
Mar 4, 2015	2015_217137_0011	L-001832-15	Resident Quality Inspection

Licensee/Titulaire de permis

MEADOW PARK (LONDON) INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

MEADOW PARK (LONDON) INC.
1210 SOUTHDALE ROAD EAST LONDON ON N6E 1B4

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

MARIAN MACDONALD (137), BONNIE MACDONALD (135), DONNA TIERNEY (569), NATALIE MORONEY (610)

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): February 3 - 6 and 9 -12, 2015.

A Critical Incident System Inspection under 001061-15 and a Complaint Inspection under 009661-14 were conducted in conjunction with RQI.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Resident and Family Services Coordinator, Restorative Care Coordinator, two (2) Staff Educators, Volunteer Services Coordinator, Environmental Services Supervisor, Care Services Coordinator, Office Manager, Registered Dietitian, Food Service Supervisor, Staffing Coordinator, Hairdresser, five (5) Registered Nurses, four (4) Registered Practical Nurses, twenty (20) Personal Support Workers/Health Care Aides, three (3) Dietary Aides, one (1) Cook, two (2) Housekeepers, one (1) Laundry Aide, forty + (40+) Residents and three Family Members.

The Inspectors also toured all resident home areas, common areas, laundry room, kitchen, medication storage area, observed dining service, care provision, resident/staff interactions, recreational programs, medication administration, reviewed residents' clinical records, relevant policies and procedures, staff education records and various meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **17 WN(s)**
- **11 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 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. A written notification of non-compliance and a voluntary plan of correction were previously issued on May 2, 2012, a Compliance Order was previously issued on December 12, 2012 under L- 001149-12, Inspection # 2012_217137_0053 and a written notification of non-compliance and a voluntary plan of correction were previously issued on April 30, 2014, under L-000386-14, Inspection # 2014_255516_0013 related to the infection prevention and control program.

The Licensee failed to ensure that staff participate in the implementation of the infection prevention and control program as evidenced by the following:

During Lunch service in the Main Dining room, staff members were observed clearing resident's soiled soup bowls and lunch plates then serving residents their main course or desserts without practicing hand hygiene between residents.

In an interview, the home's Food Service Supervisor confirmed the expectation that staff participate in the implementation of the infection prevention and control program when serving resident meals. [s. 229. (4)]

2. The licensee has failed to ensure all staff participate in the implementation of the infection prevention and control program as evidenced by:

Observations, throughout the RQI, revealed infection control risks identified in shared resident rooms/washrooms.

Personal care items, such as toothpaste, toothbrushes, hair brushes, electric razor, bedpans, urinals, etc., were not labeled and stored properly in fourteen (14) identified shared washrooms.

Improperly stored items, such as urinals containing urine, were observed to be stored on various bed rails and nightstands, throughout the home.

During a tour of the home, with the Administrator and Environmental Services Supervisor on February 9, 2015, it was confirmed that the identified personal care items were not labeled and/or stored properly posing a potential infection prevention and control risk to residents, as well as the expectation that all personal care items be labeled and stored properly, especially in shared resident rooms/washrooms. [s. 229. (4)]

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. A written notification of non-compliance and a voluntary plan of correction were previously issued on May 2, 2012, a Compliance Order was previously issued on December 12, 2012 under L- 001149-12, Inspection # 2012_217137_0053 and a written notification of non-compliance and a voluntary plan of correction were previously issued on April 30, 2014, under L-000386-14, Inspection # 2014_255516_0013 related to the home, furnishings and equipment being kept clean and sanitary, as well as being maintained in a safe condition and in a good state of repair.

The Licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary as evidenced by the following:

During a walking tour of the home's Main Kitchen, February 9, 2015, with the Food Service Supervisor the following unclean areas were observed:
• Walk in refrigerator had build-up of dirt and black debris in corner of fridge on right hand side inside door on the floor
• Refrigerator floor had numerous black marks
• Refrigerator ceiling had hanging dust and fan covers were noted to have build-up of black dust.
• Numerous carts in the refrigerator were soiled with dried on food waste

• Black mould like substance on outer hinge of door of walk in refrigerator at floor level
• Rusted pipes and peeling paint on pipes noted over steamer
• Hand can opener blade heavy build up of food waste and dried on food/juice drippings
• Dirty floor behind convection oven
• Lower stacked steamer had numerous splatters of food waste
• Dirty fan cover blowing on clean dishes at end of the dish machine.
• Wall board above clean end of dish machine peeling and not repaired
• Mould like growth under dirty end of the dish machine by washing dispenser
• Wall under counter by dirty end of dish machine had numerous food/fluid spatters

During an interview, the Food Service Supervisor confirmed the expectation that the home's furnishings and main kitchen production equipment be kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee ensured that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair as evidenced by:

Observations, throughout the RQI, revealed identified deficiencies including:
(a) damaged and paint chipped doors, door frames, walls and baseboards in thirty (30) resident rooms, as well as in common areas of the home
(b) burnt out light bulbs in common areas and over bed lights
(c) stained ceiling tiles throughout the home
(d) notably damaged seat covers on feeding stools in Elgin/Oxford dining room
(e) damaged finish on wooden chair legs and armrests.
(f) bath tubs cracked and protective edging in disrepair and tubs not able to be disinfected properly in Kent and Lambton tub rooms; Elgin tub has not been operational since October/November 2014.

During a tour of the home, with the Administrator and Environmental Services Supervisor on February 9, 2015, the identified deficiencies were confirmed, as well as the expectation that the home, furnishings and equipment be maintained in a safe condition and in a good state of repair. [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. 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 minimum, twice a week by the method of his or her choice as evidenced by the following:

During this inspection residents shared with Inspectors they were not provided their two baths weekly.

Interviews with staff and record review revealed that the residents were not receiving 2 baths per week.

Bathing records were reviewed for 9 residents and it was noted that all 9 (100%) of the residents missed a total of 41 baths (19%) from November 1, 2014, until January 31, 2015.

The bathing records for an identified resident revealed the resident had not been bathed on 4 occasions or 50% of the time, in a one month period.

The Elgin bath tub has not been operational since October/November 2014, contributing to missed and/or delayed baths.

During an interview the Director of Care confirmed that baths are not always completed.

During an interview, the Administrator and the Director of Care confirmed their expectations that each resident of the home is bathed at minimum, twice a week by the method of his or her choice [s. 33. (1)]

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 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 failed to ensure the Nutrition and Hydration program includes a weight monitoring system to measure and record with respect to each resident, weights being taken on admission and monthly thereafter as evidenced by:

November 1, 2014 to January 31, 2015, 37 (31.6%) of the residents did not have their weights taken monthly on 56 occasions or (50.4%) of the time.

In an interview, the home's Registered Dietitian confirmed that weights are not always available each month for her to assess the resident's nutritional status.

During an interview, the Administrator confirmed the expectation is there be a weight monitoring system with respect to each resident, ensuring that residents are weighed on admission and monthly thereafter. [s. 68. (2) (e) (i)]

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 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:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs as evidenced by:

Observations, throughout the RQI, revealed seven (7) identified residents with facial hair present and were not being consistently shaved.
Three (3) identified residents were frequently observed with dark debris embedded under their fingernails.

Personal support workers shared, due to staffing shortages, residents are not being bathed, receiving nail care and being shaved.

A registered staff member confirmed residents were not shaved and dark debris was embedded under the fingernails, as well as the expectation that residents are to be groomed and cared for in a manner consistent with his or her needs. [s. 3. (1) 4.]

2. The licensee has failed to ensure every resident has the right to 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 as evidenced by:

a) On February 6th, 2015, an observation on Kent floor west hallway revealed the Point of Care (POC) terminal to be unlocked and unattended with resident personal health information visible.
This was confirmed by the Administrator.
b) On February 9th, 2015, observed the POC terminal on the Kent floor west hallway to be unlocked and unattended with resident personal health information visible.
This was confirmed by a Registered Staff Member.
c) On February 10th, 2015, observation on the Oxford hallway revealed the POC terminal to be unlocked and unattended with resident personal health information visible.
This was confirmed by the Administrator.

An interview with the Administrator confirmed the expectation is that the Point of Care terminals are locked at all times when not in use to ensure residents personal health information is kept confidential. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs and to ensure every resident has the right to 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, to be implemented voluntarily.

WN #6: 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. A written notification of non-compliance and a voluntary plan of correction were previously issued on December 12, 2012 under L- 001149-12, Inspection # 2012_217137_0053 related to the home not being a safe and secure environment for its residents.

The licensee has failed to ensure that the home is a safe and secure environment for its residents as evidenced by:

Observations, during the initial tour and throughout the RQI, revealed:

1. During the initial tour on Feb 3, 2015 at 10:20, the emergency exit door on Elgin wing, leading to an unsecure area outside of the home, was observed to be unlocked and the alarm not activated.

A Personal Support Worker and the Resident Family Services Co-ordinator confirmed the door was not secured.

Further observations, between 10:45 and 10:55, revealed the emergency door on Kent wing, leading to an unsecure outside area of the home was unlocked, as well as the Kent Stairway B door.

A Registered Staff Member and the Registered Dietitian confirmed the emergency doors were not secured.

Interviews with the Administrator and the Environmental Services Supervisor revealed that the door magnetized lock system was disengaged, inadvertently, by contractors, who were doing renovations in the home earlier that day and the contractors/home were not aware of the situation, until informed by inspectors.

Both the Environmental Services Supervisor and the Administrator confirmed that all doors leading to stairways and outside unsecure areas of the home should be locked and secured, at all times.

2. On February 3, 2015 at 2:29 pm, a bottle of Everyday Disinfectant (ED) was observed in unlocked cupboard in Lambton Dining Room, accessible to residents.
The dining room door was observed propped open, as the push button lock on the door was in disrepair and not locking properly. Signage on door indicates the door is to be kept locked at all times.

The observation was confirmed by a Personal Support Worker and Environmental Services Supervisor, as well as the expectation that hazardous substances be in a locked cupboard and not accessible to residents.

3. On February 9, 2015 at 8:35 am, the Oxford tub room was observed propped open, with a wooden door stopper and no staff members were present. A bottle of Everyday Disinfectant (ED) was on the back of the bath tub and accessible to residents.
A Personal Support Worker confirmed residents had access to the hazardous substance, as well as the expectation that the tub room be locked when staff members are not present, to ensure residents do not have access to any hazardous substances

4. Physiotherapy Room – the door to the Hydrocollater, containing hot packs, does not have the capability to be locked. During the RQI, a resident was observed using the exercise bike independently, with no staff present.

The Administrator confirmed the door did not lock, posing a safety risk to residents, and

residents should not be left unattended in the physiotherapy room.

5. Lambton Tub/Shower Room – The call bell could be activated but was wrapped around the hand rail and could only be activated at the top of the cord, which was out of reach to residents.

6. Oxford/Elgin Dining Room – two (2) call bells could be activated but the cord was cut/shortened, not allowing resident access, especially to those residents seated in wheelchairs.

The Administrator and Environmental Services Supervisor confirmed the cords were too short and not accessible to residents, as well as the expectation that the call bell cords be accessible to residents. [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 is a safe and secure environment for its residents, to be implemented voluntarily.

WN #7: 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. (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 has failed to ensure that the plan of care set out in the plan of care is provided to the resident as specified in the plan as evidenced by:

A clinical record review revealed an identified resident has sustained frequent falls and was at high risk of falling.

The plan of care indicates a falling leaf logo is to be above the bed, a falls impact mat at bedside, chair/bed alarms to be used and call bell pinned to clothing when in bed.

An observation revealed the interventions were not in place and the call bell was not within reach.

The Administrator confirmed the interventions were not in place and the home's expectation is that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #8: 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. A written notification of non-compliance was previously issued on May 2, 2012, a Compliance Order was previously issued on December 12, 2012 under L- 001149-12, Inspection # 2012_217137_0053 and a written notification of non-compliance and a voluntary plan of correction were previously issued on April 30, 2014 under L-000386-14, Inspection # 2014_255516_0013 related to any plan, policy, protocol, procedure, strategy or system put in place not complied with.

The Licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with as evidenced by:

The homes' Monthly Weights and Weight Variance Report policy and procedure November 4, 2014 states:

PSW will reweigh residents with a 2.5 kg. change in weight from the most recent weight. All reweighs to be completed prior to the 20th of the month.

Record review revealed the home's reweigh policy was not complied with for 6/11 (54.5%) of the residents reviewed for reweighs.

In an interview the home's Registered Dietitian, it was confirmed that reweighs were not always being done as per the homes' policy .

During an interview the Administrator confirmed her expectation that the homes' Monthly Weights and Weight Variance Report policy and procedure is complied with when residents need to be reweighed. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system put in place is complied with as evidenced by:

A review of the Lost Clothing Policy, # MLM 21.1- January 2013 indicates
Resident/Nurses/Families notify ESS or document lost clothing (description, size, colour, etc) on MLF 6.1 Lost Clothing Checklist form and notify ESS.
ESS notifies laundry aide and housekeeping who search for lost item.
Nursing notifies PSW who searches in resident's room.
Found items are checked for proper label and labeled if required, return to resident and record on the MLF 6.1 form.

Unclaimed or unlabeled items are displayed on open days, the last week of each month, to residents/families.
A record review revealed there was one form completed, by the Administrator, in January 2015.

The Environmental Services Supervisor, Registered Nursing Staff and Laundry Aide confirmed the forms are not being completed, the home's policy is not being followed and the expectation is the policy be complied with, to ensure any lost clothing is identified and returned to residents. [s. 8. (1) (b)]

3. The licensee failed to put in place any plan, policy, protocol, procedure, strategy or system put in place is complied with as evidenced by:

(a) A review of the home's Resident Abuse policy indicates staff members, volunteers, Substitute Decision Makers, family members or any other person who has the reasonable ground to suspect abuse or neglect of a resident, must report their suspicion to the most senior administrator personnel on site at the home or call the online pager to report an incident of alleged, suspected or actual abuse.
A witnessed incident was not reported to Management until five (5) days after the incident occurred.

The Administrator and Director of Care confirmed it is the expectation of the home that all abuse be reported to management immediately.

(b)The policy also indicates qualified registered staff members or volunteers who have reasonable grounds to suspect abuse or neglect of a resident should assess the resident.
There was no documented evidence that an identified resident was assessed after being restrained with a prohibited device.

The Administrator and Director of Care confirmed that when an incident of alleged, suspected or actual abuse has occurred, a head to toe assessment is to be completed and results will be documented in Point Click Care (PCC).

(c) The policy also indicates to notify the Resident's Physician and immediately notify the Residents substitute decision maker. Notification must be within 12 hrs of becoming aware of the incident.
There is no documented evidence that the physician or SDM were notified of the

incident.

The Administrator confirmed that it is the expectation of the home to notify both the physician and SDM. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so as evidenced by:

Observations in four (4) home areas revealed there were no easy chairs in 22/42 (51.2%) of resident rooms.

In an interview, the Administrator confirmed that more chairs need to be purchased to ensure that every resident is provided a comfortable easy chair in the resident's bedroom, either the resident's own chair or one provided by the home. [s. 12. (2) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The Licensee failed to ensure that the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work as evidenced by:

A review of the staffing schedules with the Staffing Coordinator for 8 days from November 28, 2014, to January 25, 2015, revealed there were 4 shifts (50%) not filled or only partially filled when nursing and personal care staff did not come to work, despite the current back-up plan being utilized.

Negative outcomes to residents were noted during this time as all residents did not receive two (2) baths per week, and were not weighed monthly.

During an interview the Director of Care confirmed the home's present staffing plan was not working when staff shortages resulted in resident's not being provided two (2) baths per week and not being weighed monthly.

The Administrator confirmed her expectation that the staffing plan include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, ensuring a staffing mix that is consistent with resident's assessed care and safety needs. [s. 31. (3)]

2. The licensee failed to ensure that there was a written record of an annual evaluation of the staffing plan in 2014 including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented as evidenced by the following:

During record review and interview with Director of Care it was determined there was no documented evidence to support that the staffing plan has been evaluated in 2014.

In interview with the Administrator she acknowledged that although she was aware that there was a requirement to do an annual evaluation, the home did not conduct a formal evaluation process for staffing in 2014. [s. 31. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, to be implemented voluntarily.

WN #11: 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 the resident has fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls as evidenced by:

A clinical record review revealed an identified resident had sustained several falls. The post fall assessment tools were incomplete (did not identify/include medication review, assistive devices used, bed alarms, fall impact mats, etc.) for all falls (100%). Registered staff shared there was confusion as to which tool was to be completed. Risk reports had been removed but were re-implemented as of February 6, 2015.

The Administrator confirmed that it is the home's expectation to fully complete post fall assessments in PCC. [s. 49. (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 ensure that when the resident has fallen, the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #12: 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 as evidenced by the following:
Lunch service February 3, 2015, in the main dining room the minced peaches for the fruit salad plate and butterscotch pudding were not available and/or offered as per the posted menu.

During lunch service February 6, 2014, the planned menu items for an identified resident were not available.

In an interview the Food Service Supervisor confirmed the expectation is that planned menu items are offered and available at each meal as per the posted menu. [s. 71. (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 planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure that all food and fluids were prepared, stored, and served using methods which preserve taste, appearance and food quality as evidenced by the following:

Record review of the home's Food Committee Meeting minutes since August, 2014 revealed that the home's steam jacketed soup kettle is not working.

Residents were advised at the Food Committee meeting, September 18, 2014, that the kettle cannot be fixed and a replacement needs to be purchased.

At the January 13, 2015, Food Committee Meeting residents complained that the soup is curdling. At that meeting the Food Service Supervisor reported that the soup is now being heated in the steamer, causing it to curdle.

In an interview, the cook shared that the soup kettle no longer works and putting it in the steamer can result in it curdling, when it gets too hot. Staff also revealed one of the steamers has not worked for the last two (2) years as it blows the breakers.

During an interview the Food Service Supervisor confirmed her expectation that all food and fluids are prepared, stored, and served using methods which preserve taste, appearance and food quality. [s. 72. (3) (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 all food and fluids were prepared, stored, and served using methods which preserve taste, appearance and food quality, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on May 2, 2012, as well as a Compliance Order was previously issued on December 12, 2012 under L- 001149-12, Inspection # 2012_217137_0053 related to the home not having a sufficient supply of clean linens available for use by the residents and linens not being in a good state of repair, free from stains.

The licensee has failed to ensure that there a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the resident as evidenced by:

Throughout the RQI, interviews were conducted with nine (9) staff members and all revealed that the home frequently runs out of linens on a daily basis, including top sheets, bottom sheets, pillow cases, face cloths and bath towels. Staff confirmed there are insufficient linens available to complete scheduled linen changes, on a daily basis.

On February 5, 6 and 9, 2015, a tour of the care carts and linen rooms on three (3) of (four) 4 (75%) home areas revealed there was an insufficient supply of clean linens, face cloths, towels and sheets always available in the home for use by the residents.

During a tour of the home, with the Administrator and Environmental Services Supervisor on February 9, 2015, it was confirmed the home did not have a sufficient supply of clean linens available for use by the residents and linens were not in a good state of repair, free from stains, as well as the expectation that there be a sufficient supply of clean linens available for use by the residents and linens be in a good state of repair, free from

stains. [s. 89. (1) (b)]

2. The licensee has failed to ensure that linens, face cloths and bath towels, are kept clean and sanitary, maintained in a good state of repair, and free from stains and odours as evidenced by:

Observations, throughout the RQI, revealed, sheets and pillow cases to be stained, worn, in disrepair and discoloured, mattress covers to be stained and worn, as well as twenty+ (20+) cracked/damaged pillows.

During a tour of the home, with the Administrator and Environmental Services Supervisor on February 9, 2015, it was confirmed the home did not have a sufficient supply of clean linens available for use by the residents and linens were not in a good state of repair, free from stains, as well as the expectation that there be a sufficient supply of clean linens available for use by the residents and linens be in a good state of repair, free from stains. [s. 89. (1) (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 the home has a sufficient supply of clean linens available for use by the residents and linens be in a good state of repair, free from stains and odours, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on December 2, 2013 under L-000941-13, Inspection # 2013_303563_0006.

The Licensee failed to ensure that devices to limit movement are not used in the home as evidenced by:

An identified resident was restrained using a prohibitive device, restricting the resident's movement.

The Administrator and Director of Care confirmed the prohibited restraining device restricted the resident's movement and the expectation is the device not be used as a restraining device. [s. 112. 7.]

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 the home does not use prohibited restraining devices that limit movement, to be implemented voluntarily.

WN #16: 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).

Findings/Faits saillants :

1. The Licensee failed to ensure that resident was provided with eating aids and assistive devices, required to safely eat and drink as comfortably and independently as possible as evidenced by the following:

During lunch service February 6, 2014, an identified resident was not provided an assistive device.

In an interview, the Food Service Supervisor confirmed the expectation is that residents are provided with eating aids, and assistive devices required to safely eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM had been immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being as evidenced by:

The Administrator and Director of Care confirmed that the SDM was not notified of an incident, where a resident was restrained using a prohibitive device that restricted the resident's movement.

The Administrator confirmed that it is the expectation of the home to notify SDM immediately, of incidents related to abuse. [s. 97. (1) (a)]

Issued on this 10th day of March, 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) :	MARIAN MACDONALD (137), BONNIE MACDONALD (135), DONNA TIERNEY (569), NATALIE MORONEY (610)
Inspection No. / No de l'inspection :	2015_217137_0011
Log No. / Registre no:	L-001832-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 4, 2015
Licensee / Titulaire de permis :	MEADOW PARK (LONDON) INC 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	MEADOW PARK (LONDON) INC. 1210 SOUTHDALE ROAD EAST, LONDON, ON, N6E-1B4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Melanie Smith

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

To MEADOW PARK (LONDON) 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 :

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

Order / Ordre :

The licensee must take immediate action to achieve compliance by:

(a) ensuring all staff participate in and receive education related to the implementation of the infection prevention and control program, including hand hygiene practices.

(b) ensuring all residents' personal care items and equipment are kept clean, labeled and stored properly to mitigate infection control risks to residents.

Grounds / Motifs :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on May 2, 2012, a Compliance Order was previously issued on December 12, 2012 under L- 001149-12, Inspection # 2012_217137_0053 and a written notification of non-compliance and a voluntary plan of correction were previously issued on April 30, 2014, under L-000386-14, Inspection # 2014_255516_0013 related to the infection prevention and control program.

The licensee has failed to ensure all staff participate in the implementation of the infection prevention and control program as evidenced by:

Observations, throughout the RQI, revealed infection control risks identified in shared resident rooms/washrooms.

Personal care items, such as toothpaste, toothbrushes, hair brushes, electric razor, bedpans, urinals, etc., were not labeled and stored properly in fourteen (14) identified shared washrooms.

Improperly stored items, such as urinals containing urine, were observed to be stored on various bed rails and nightstands, throughout the home.

During a tour of the home, with the Administrator and Environmental Services Supervisor on February 9, 2015, it was confirmed that the identified personal care items were not labeled and/or stored properly posing a potential infection prevention and control risk to residents, as well as the expectation that all personal care items be labeled and stored properly, especially in shared resident rooms/washrooms.
(137)

2. The Licensee failed to ensure that staff participate in the implementation of the infection prevention and control program as evidenced by the following:

During Lunch service in the Main Dining room, staff members were observed clearing resident's soiled soup bowls and lunch plates, then serving residents their main course or desserts, without practicing hand hygiene between residents.

In an interview, the Food Service Supervisor confirmed the expectation that staff participate in the implementation of the infection prevention and control program when serving resident meals.
(135)

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

The licensee must take immediate action to 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.

The licensee must take immediate action to achieve compliance by:
(a) ensuring the kitchen walls, flooring, equipment (steamer, carts, walk-in refrigerator, can opener, etc.,) and base boards are cleaned to remove food/fluid splatters, dust, black marks and debris.
(b) ensuring a process is in place to monitor on-going compliance in order that the home's furnishings and main kitchen production equipment be kept clean and sanitary.

The licensee must take immediate action to achieve compliance by:
(a) ensuring damaged and paint chipped doors, door frames, walls and base boards, throughout the home, are repaired and painted.
(b) ensuring all burnt out light bulbs are replaced in light fixtures throughout the home.
(c) ensuring stained ceiling tiles are replaced throughout the home
(d) ensuring damaged feeding stools in Elgin/Oxford dining room are repaired or replaced.
(e) ensuring the damaged finish on dining room chairs (legs and armrests) in Lambton dining room and lounge area are repaired.
(f) ensuring the damaged bath tubs, in Kent, Lambton and Elgin tub rooms, are repaired.
(g) ensuring missing/loose electrical covers are replaced/repaired.
(h) ensuring there is a process in place to monitor on-going compliance in order that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Grounds / Motifs :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on May 2, 2012, a Compliance Order was previously issued on December 12, 2012 under L- 001149-12, Inspection # 2012_217137_0053 and a written notification of non-compliance and a voluntary plan of correction were previously issued on April 30, 2014, under L-000386-14, Inspection # 2014_255516_0013 related to the home, furnishings and equipment being kept clean and sanitary, as well as being maintained in a safe condition and in a good state of repair.

The Licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary as evidenced by:

During a walking tour of the home's Main Kitchen, February 9, 2015, with the Food Service Supervisor the following unclean areas were observed:
• Walk in refrigerator had build-up of dirt and black debris in corner of fridge on right hand side inside door on the floor
• Refrigerator floor had numerous black marks
• Refrigerator ceiling had hanging dust and fan covers were noted to have build-up of black dust.
• Numerous carts in the refrigerator were soiled with dried on food waste
• Black mould like substance on outer hinge of door of walk in refrigerator at floor level
• Rusted pipes and peeling paint on pipes noted over steamer
• Hand can opener blade heavy build up of food waste and dried on food/juice drippings
• Dirty floor behind convection oven
• Lower stacked steamer had numerous splatters of food waste
• Dirty fan cover blowing on clean dishes at end of the dish machine.
• Wall board above clean end of dish machine peeling and not repaired
• Mould like growth under dirty end of the dish machine by washing dispenser
• Wall under counter by dirty end of dish machine had numerous food/fluid spatters

During an interview, the Food Service Supervisor confirmed the expectation that the home's furnishings and main kitchen production equipment be kept clean and sanitary.
(135)

2. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair as evidenced by:

Observations, throughout the RQI, revealed identified deficiencies including:
(a) damaged and paint chipped doors, door frames, walls and baseboard in thirty (30) resident rooms, as well as common areas of the home.
(b) burnt out light bulbs in common areas and over bed lights.
(c) stained ceiling tiles throughout the home.
(d) significantly damaged seat covers on feeding stools in Elgin/Oxford dining

room.
(e) damaged finish on wooden chair legs and armrests.
(f) bath tubs cracked and protective edging in disrepair and tubs not able to be disinfected properly in Kent and Lambton tub rooms; Elgin bath tub has not been operational since October/November, 2014.

During a tour of the home, with the Administrator and Environmental Services Supervisor on February 9, 2015, the identified deficiencies were confirmed, as well as the expectation that the home, furnishings and equipment be maintained in a safe condition and in a good state of repair.

(137)

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

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. 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).

Order / Ordre :

The licensee must take immediate action to achieve compliance by:
(a) completing a comprehensive review of bathing schedules and documentation to identify gaps in recording of baths.
(b) provide education to nursing and personal care staff to ensure they are aware of bathing requirements and documentation expectations.
(c) evaluate the system that is in place related to identification of missed baths and subsequent scheduling at an alternate time.
(d) ensure the Elgin bath tub is repaired to prevent delays in residents receiving scheduled baths.

Grounds / Motifs :

1. The licensee failed to ensure that each resident of the home was bathed at minimum, twice a week by the method of his or her choice as evidenced by the following:

During this inspection residents shared with Inspectors they were not provided their two baths weekly.

Interviews with staff and record review revealed that the residents were not receiving two (2) baths per week.

Bathing records were reviewed for nine (9) residents and it was noted that all nine (9) residents (100%) of the residents missed a total of 41 baths (19%) from November 1, 2014, until January 31, 2015.

The bathing records for an identified resident revealed the resident had not been bathed on 4 occasions or 50% of the time, in a one month period.

The Elgin bath tub has not been operational since October/November 2014, contributing to missed and/or delayed baths.

During an interview the Director of Care confirmed that baths are not always completed.

During an interview, the Administrator and the Director of Care confirmed their expectations that each resident of the home is bathed at minimum of twice a week by the method of his or her choice.
(135)

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(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).

Order / Ordre :

The licensee must take immediate action to achieve compliance by:
(a) ensuring residents are weighed on admission and monthly thereafter, as well as re-weighed when a discrepancy or weight change has been identified, in order for the nutritional status of residents be accurately assessed.
(b) ensuring a process is in place to monitor on going compliance related to weight monitoring.

Grounds / Motifs :

1. The Licensee failed to ensure the Nutrition and Hydration program includes a weight monitoring system to measure and record with respect to each resident, weights being taken on admission and monthly thereafter, as evidenced by:

November 1, 2014 to January 31, 2015, 37 (31.6%) of the residents did not have their weights taken monthly on 56 occasions or (50.4%) of the time.

In an interview the home's Registered Dietitian confirmed that weights are not always available each month for her to assess the resident's nutritional status.

During an interview the Administrator confirmed her expectation there be a weight monitoring system with respect to each resident, ensuring that residents are weighed on admission and monthly thereafter. (135)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 10, 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 4th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARIAN MACDONALD

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