Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
May 21, 2014;	2014_140158_0005 (A1)	S-000010-14	Resident Quality Inspection

Licensee/Titulaire de permis

675412 ONTARIO INC
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

NORTHVIEW NURSING HOME
77 RIVER ROAD, P.O. BOX 1139, ENGLEHART, ON, P0J-1H0

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

Ontario

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KELLY-JEAN SCHIENBEIN (158) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

date changed at the request of the licensee

Issued on this 21 day of May 2014 (A1)

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

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KELLY-JEAN SCHIENBEIN (158) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 24-28, 2014 and March 31-April 4, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), the Assistant Director of Care, Registered Nursing Staff, Personal Support

Workers, Environmental Services Manager, Nutrition Manager, RAI Coordinators, Dietary staff, Housekeeping/Laundry staff, Recreational Co-ordinator, Resident Council members, Families and Residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident home areas, observed staff to resident interactions, reviewed health care records and various policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Dignity, Choice and Privacy

Dining Observation

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

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The Inspectors observed that mattresses were not securely fitting 13/13 residents' bed frames.
The Administrator provided Inspector # 158 with the 2013 mattress/bed survey, conducted by an outside company. The survey identified that replacement of 17 mattresses was required related to the potential of entrapment in zone 2 and 4. The survey also identified that one of the newer electric beds had a mattress, which did not fit the frame and could cause a potential entrapment in zone 7.
On April 3, 2014, Inspector # 158 and the Environmental Service Manager toured the home to inspect the bed frames and mattresses, which were in use by residents. It was noted that the "bed rolled edged" mattresses did not fit in either the older style "manual" bed frame or in the bed frames, which were purchased in 2010. It was noted, as well, that three of the newly purchased beds (2010) did not have the wire at the end of the frame, which would keep the mattress in place. The older beds had plastic brackets at the ends of the frame, which would keep a mattress in place, however, the brackets on 2 bed frames were broken.
It was noted during this tour and coupled with the identified 2013 bed/mattress survey, that 26 of the 48 residents, who reside in the home have mattresses, which do not fit the bed frame and pose a potential risk of injury, including possible entrapment in zones 2, 4 and 7.
The licensee did not ensure that the home is a safe and secure environment related to mattresses which do not securely fit bed frames for residents. [s. 5.]

2. An environmental consulting firm, engaged by the home identified that asbestos containing material was present in the home. As part of the firm's recommendations, it was identified in a letter to the home, that the Administrator needs to ensure that an annual inspection is conducted by the maintenance staff to update the condition of any accessible asbestos containing materials within the building and that these inspections should occur in March of each year. The Asbestos Management Program book was reviewed by Inspector # 158 and no documented inspections were noted. The Health and Safety Committee's lead and the Administrator identified that inspections are done monthly, however there is no supporting documentation. [s. 5.]

3. On April 3, 2014, Inspector # 158 observed that resident owned small appliances, such as fans, radios and televisions were plugged into power bars, which were mounted on the wall in 4/4 residents' rooms. When asked whether the resident owned appliances, such as the above were inspected by maintenance, as per the home's policy, the Environmental Manager stated that at times, it is the nursing staff that preforms this assessment. There was no documentation, at the time of the review to identify that appliances such as fans, radios, clocks, razors, were inspected. [s. 5.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.
On April 1, 2014, Inspector # 544 reviewed resident # 8004 health care record, including assessments and care plan.
Resident # 8004 had a change in condition since being admitted into the home.
The dietitian assessed the resident when the resident was admitted and ordered a specific diet for the resident. Subsequent dietary assessments by the dietitian, were not found.
A quarterly assessment by the nursing staff, identified only, that the resident was at a nutritional risk. The resident's diet was not identified.
It was confirmed by staff # 102 on April 1, 2014, that resident # 8004 has been on a different diet than what was originally ordered by the dietitian.
The Inspector noted that the diet ordered by the dietitian was documented on the "Dietary Nourishment List" and differed from what was documented in resident # 8004 care plan.
The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to resident # 8004. [s. 6. (1) (c)]

2. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.
Resident # 7971 was transferred to the hospital for assessment. It was later documented that the resident had altered skin integrity upon resident # 7971's return to the home.
On April 2, 2014, the Inspector reviewed Resident # 7971 health care record. There was no indication that a skin assessment was completed when the resident returned from hospital as indicated in the home's policy.
Resident # 7971 plan of care was also reviewed and there were interventions documented for altered skin integrity, however, the interventions documented were not related to the new area of altered skin integrity.
The plan of care did not set out clear directions to staff and others who provide direct care to resident # 7971 related to his altered skin integrity and catheter use. [s. 6. (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 ensuring that clear directions for resident care is set out in the plan of care, specifically residents # 7971 and #8004, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the home, furnishings and equipment are kept clean and sanitary.
On March 24, 2014, an odour was noted by the Inspectors when they first entered the home. The odour was present throughout the home and lingered until the Inspectors left. On March 31, 2014, Inspector # 158 toured the home and noted that an odour was present in the home. Upon investigation, the Inspector found that the commodes in two residents' bedrooms, had urine in the pails and that in 9 residents' bathrooms, 9 toilet plungers had visible dried brown foul smelling matter on the outside bottom area. It was also noted that stagnant smelling water was in a bucket in the tub room where the tub cleaning brushes were kept.
On March 31, 2014, the Inspector spoke with staff # 107 and # 113, who identified that the commodes are cleaned and disinfected once a week. Staff # 107 also identified that the PSW will use "virox" pads to wipe down the commodes after each use. Inspector spoke with staff # 106, who told the Inspector, that it is usually the housekeeping staff that clean the commodes but a PSW will at times, use "virox" pads to wash the commode's surface after it is used by the resident.
Resident # 7994 shares a bathroom with three other residents. On March 31, 2014, the Inspector observed that a visitor of resident 7994 cleaned the commode's pail with water in the resident's bathroom sink, after assisting resident # 7994 with toileting.

The Inspector did not observe that the sink or commode/pail was cleaned or wiped down, after the resident used the commode.
On April 1, 2014, Inspector # 158 noted that there was a strong urine smell in the resident's room. The Inspector observed that resident # 7994's commode's pail was filled with urine. Inspector # 543 noted the odour again two hours later and that the commode's pail was still filled with urine.
As well, two wheelchairs located in the hallway were observed to be soiled and stained.
The licensee did not ensure that the home, furnishings and equipment, specifically commodes and plungers were kept clean and sanitary. [s. 15. (2) (a)]

2. Throughout the home, there were many walls and surfaces which were scratched, gouged and in need of painting or repair.
The following observations were made by Inspector # 158, # 543 and # 544 throughout the Inspection.
The bathroom cupboards in room 135 were scratched and required painting. The wall tiles above these cupboards were also cracked.
The bedroom walls in two rooms had many holes, nails, were scratched and required painting.
There were gouges present on the bathroom walls of one resident's bathroom.
The tiles above the sink in another resident's bathroom were cracked and the cupboards below the sink required painting.
The lower portion of the hallway walls as well as many resident doors were scratched and gouged in areas.
Cracks were present in the wall above the door of a room which was previously repaired related to a leak in the roof.
Many radiators in residents' rooms with metal caging on them are scratched and require painting.
The licensee did not ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that continence equipment is emptied and cleaned after each use; that all continence equipment is cleaned in the dirty utility room and that the toilet plungers are cleaned and stored in the dirty utility room, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The home's policy related to minimizing the restraining of residents, identifies that an order for a restraint is obtained from a physician or Registered Nurse from the extended class; that a consent for the use of the restraint is obtained from the resident or Substitute Decision maker and that when a restraint is used, documentation of assessment, reassessment, monitoring, release of the device, and all repositioning is completed.
Resident # 7971 has a front fastening seat belt, which the resident was not able to undo and thus it was a restraint for the resident.
Inspector #543 reviewed resident #7971's health care record and found that there was a physician's order for the front fastening seat belt, however, the order is dated over two years ago. The Administrator confirmed that there was no current order.
Inspector #543 spoke with the Administrator regarding consent forms for restraints. The Administrator stated that the consent forms are located in the resident's paper chart and that the consent forms are not to be removed. The consent form for resident # 7971 restraint was not located when the Administrator and Inspector # 543 reviewed the chart.
As well, the resident's health care record did not have flow sheets identifying that staff are signing that the resident is being monitored at least every hour by the Registered staff or by another staff members, who are authorized by a member of the registered staff for that purpose; as per the Home's Restraint Policy.

Consequently, the licensee did not ensure that its written policy to minimize the restraining of residents was complied with. [s. 29. (1) (b)]

2. The licensee did not ensure that its written policy related to minimizing the restraining of residents was complied with.
The home's policy identifies that an order for a restraint is obtained from a physician or Registered Nurse from the extended class; that a consent for the use of the restraint is obtained from the resident or Substitute Decision maker and that when a restraint is used, that documentation of assessment, reassessment, monitoring, release of the device, and all repositioning is completed.
Inspector # 158 observed that resident # 8010 was sitting in a wheel chair with a front fastening seat belt in place, on March 31, April 1 and 2, 2014. It was confirmed by staff # 103 that resident # 8010, who has severe cognitive impairment, could not undo the seat belt and thus it was a restraint for the resident. Inspector # 158 reviewed the resident's health care record and found that an order and consent for a Personal Assistance Service Device (PASD) was obtained from the physician for the resident's seat belt and not an order for a restraint. The health care record did not contain a consent for the seat belt restraint.
The licensee did not ensure that the home's policy related to obtaining an order or consent was complied with. [s. 29. (1) (b)]

3. It was identified by staff # 103, that resident # 7985, who was sitting in a wheel chair (w/c) could not undo the seat belt and thus it was a restraint for the resident. Inspector # 158 reviewed resident # 7985 health care record and a consent or an order for the restraint was not found. The licensee did not ensure that the home's policy related to minimizing the restraining of residents was complied with. [s. 29. (1) (b)]

4. It was identified by staff # 103 that resident # 01, who was sitting in a w/c could not undo the seat belt and thus it was a restraint for the resident. Resident # 01 health care record was reviewed and a consent was not found for the restraint (front fastening seat belt), which was ordered by the physician. The licensee did not ensure that the home's policy related to minimizing the restraining of residents was complied with. [s. 29. (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 ensuring that the home's written policy to minimize the restraining of residents is complied with, specifically regarding consents and orders and the monitoring documentation of the restraint, to be implemented voluntarily.

WN #5: 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 did not ensure that its policies and procedures relating to nutritional care and dietary services and hydration, specifically weighing of residents monthly was implemented.
The home's weight change policy identified that every resident will be weighed monthly; weight recorded in the weight book.
On April 1, 2014, Inspector # 544 reviewed the monthly weight book. It was noted that in January 2014, 15/48 residents were not weighed and in February 2014, 32/48 residents were not weighed and resident # 8023 was not weighed over three months.
The licensee did not implement their policies and procedures related to the monthly weights of residents and recording in the weight book. [s. 68. (2) (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 ensuring that all residents are weighed monthly and that the weights are recorded, to be implemented voluntarily.

WN #6: 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 did not ensure that residents with the following weight changes, a change of 5 percent of body weight, or more, over one month; a change of 7.5 percent

of body weight, or more, over three months; a change of 10 percent of body weight, or more, over 6 months and any other weight change that compromises the resident's health status are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated.
The home's weight change policy identified that every resident will be weighed monthly; weight recorded in the weight book; and when any resident has a significant weight change of 5% in a month, 7.5% over 3 months, 10% over 6 months, the resident is reweighed. The policy also identified that the dietitian will be notified so that an assessment can be completed, and any recommendations can be added to the resident's care plan.
On April 1, 2014, Inspector # 544 reviewed resident # 8012's health care record, including assessments and weights taken.
Inspector # 544 reviewed Resident # 8012's weights for the last 6 months. It was noted by the Inspector that the resident had a loss of 7kg (12%) in one month.
There was no evidence that the resident had been reweighed. It was further noted that the resident had not been currently weighed.
The last assessment by the dietitian in the resident's health care record is dated prior to the documented weight loss. A current referral to the dietitian was not found.
Staff # 102 told the Inspector that resident # 8012 refuses am, pm, and hs snacks and that the resident eats approximately 25% of food at meal time.
The licensee failed to ensure that resident # 8012's weight change was assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. The licensee did not ensure that residents with the following weight changes, a change of 5 percent of body weight, or more, over one month; a change of 7.5 percent of body weight, or more, over three months ; a change of 10 percent of body weight, or more, over 6 months and any other weight change that compromises the resident's health status.
On April 1, 2014, Inspector # 544 reviewed resident # 8004 health care record, including assessments, laboratory reports, kardex and care plan.
It was noted by the Inspector that resident had a 7 kg loss (12%) in one month. The resident was not re-weighed as per the home's policy.
The dietary assessment completed by the Dietitian, a year ago, identified that a specific diet was ordered for resident # 8004 and that the resident required encouragement to eat and drink. It was further documented in the resident's kardex that monitoring of the resident's weight and lab values would be done. A referral to the dietitian or an assessment by the dietitian was not found nor was an assessment of resident #8004 lab values.

The licensee failed to ensure that resident # 8004 weight change was assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that residents with a significant change in weight (loss/gain) are re-weighed and that the dietitian is notified of the change so as to complete an assessment, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

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. On April 1, 2014, Inspector # 544 reviewed the home's Fall and Winter 2013-2014 (Current Menu Cycle) for meals and snacks served in the home. It was confirmed by staff # 100, that the home does not have separate menus for all therapeutic and texture modified diets for meals and snacks.
The Inspector reviewed the Nourishment list and found it to be incomplete and did not give direction to staff for all residents, who may need regular, pureed, thickened fluids, therapeutic or modified snacks.
The licensee failed to ensure that the home's menu cycle included menus for regular, therapeutic and texture modified diets for both meals and snacks. [s. 71. (1) (b)]

2. Inspector # 544 observed a dinner meal service and noted that the menu did not reflect the items of food served to the residents.
The residents received stewed tomatoes instead of French green beans that was on the menu and mixed fruit instead of diced pears that was on the menu. Herbed egg noodles were not available for the dinner meal, so spiral macaroni was served instead.
Fried eggs, whole wheat toast and fruit salad were not served at the breakfast meal as identified on Week 2 menu. Cheese yogurt and muffins were substituted.
At a lunch meal, garden salad was not served as per menu item Week 2 menu cycle.
There was no yogurt available to serve to the residents as per Week 3 menu cycle.
Staff # 100 identified that "they" run out of the menu items often and need to substitute. The food items, which are ordered by the nutrition manager, are delivered on Saturdays. It is not communicated to the kitchen staff, whether the "full order" was delivered or whether food items are on back order and not delivered, so menu items are substituted when the planned menu item is unavailable.
The licensee failed to ensure that the planned menu items are offered and available at each meal and snack. [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 ensuring that the menus include regular, therapeutic and texture modified diets for both meals and snacks and that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. Inspector # 544 reviewed the production sheets that were made available. Some of the production sheets were not dated and did not identify consistent information to support an organized food production system, which includes, the number of servings to prepare according to diet and diet textures, as well as, shortages or overproduction of menu items used for forecasting food production.
In an interview on April 1, 2014, staff # 100 and # 101 confirmed that the production sheets used by the Cooks, lacked sufficient information to support an organized food production system and do not always reflect the current menu items being served.
The licensee failed to ensure that the food production system, at a minimum, provides

for the standardized recipes and production sheets for all menus. [s. 72. (2) (c)]

2. Inspector # 544 reviewed the production sheets and obtained copies for Week 3 of the Fall/Winter 2013-2014 menu. Menu substitutions were not documented on the food production sheets. The Inspector noted that the production sheets were incomplete. Staff # 100 and 101 confirmed that the documentation of menu substitutions is not routinely done. [s. 72. (2) (g)]

3. The licensee did not ensure that the staff complied with the home's cleaning schedule, which is part of the home's policy regarding cleaning of equipment.
Inspector # 544 observed that equipment, such as dishwasher, microwave, coffee machine and stoves required cleaning.
Inspector # 544 reviewed the daily cleaning schedule of equipment, which was identified on the "daily cleaning list" for March 2014 and noted that it was incomplete. No cleaning of the equipment was documented for 17 days in March/14 and 3 days in April/14.
Inspector # 544 interviewed staff # 100 and 104, who stated, " there is no time to do the cleaning with everything else going on, we can only do so much."
At the exit interview, the Environmental Service manager, the nutrition manager and the Administrator agreed that "the kitchen needs a good cleaning, washing of the walls, repairs and a good coat of paint."
The licensee did not ensure that the staff of the home complied with its policy regarding the cleaning schedule for all the equipment. [s. 72. (7) (b)]

4. Inspector # 544 observed that the kitchen walls were dirty and were yellow in colour. There were gouges on the walls especially in the corners near the door ways and exits. The "daily cleaning list" identifies daily cleaning tasks for the food production, servery and dish washing areas. Inspector # 544 reviewed the "daily cleaning list" for March 2014 and noted that it was incomplete and that no cleaning was documented for 17 days in March/14 and 3 days in April/14.
Inspector # 544 interviewed staff # 100 and 105, who stated that the cleaning schedule has not been done according to the outlined plan and confirmed that the documentation was not complete. Both staff confirmed that they do not clean regularly. Staff # 100 told the Inspector that there has been very little maintenance done in the kitchen for "some time."
No other documentation of cleaning could be found.
The licensee did not ensure that the staff of the home complied with the cleaning schedule for the food production, servery and dish washing areas. [s. 72. (7) (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 ensuring that the food production system provides for standardized recipes and production sheets all menus; that menu substitutions are documented on the production sheets; that the cleaning schedule for all the equipment is completed and that the cleaning schedule for the food production, servery and dish washing areas is completed, to be implemented voluntarily.

WN #9: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were implemented for addressing incidents of lingering offensive odours.
On March 24, 2014, a strong urine odour was noted by the Inspectors when they first entered the home. The odour was present throughout the home and lingered until the Inspectors left. On March 31, 2014, Inspector # 158 toured the home and noted that a strong urine odour was present in the home. Upon investigation, the Inspector found that commodes in two residents' bedrooms had urine in the pails and that in 9 residents bathrooms, 9 toilet plungers had visible dried brown foul smelling matter on the outside bottom area. It was also noted that stagnant odourous water was in a bucket in the tub room where the tub cleaning brushes were kept.
On April 1, 2014, Inspector # 158 noted that there was a strong urine odour in one resident's room. Resident # 7994's commode pail was filled with urine. Inspector # 543 also noted this same odour two hours later and observed that the urine still remained in the commode's pail. The home did not ensure that incidents of lingering offensive odours were addressed. [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 ensuring that incidents of lingering odours are addressed, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair.
On March 31, 2014, Inspector # 158 observed that the toilet frame bars in resident # 7998 bathroom were loose and unsteady. The Inspector identified the unsafe equipment to staff # 102. When the Inspector toured the home with the Environmental Service Manager on April 3, 2014, it was again observed that the unsteady toilet frame remained in place.
The Inspector observed, that a raised toilet seat being used by a resident in room 144, was cracked and remained in placed even after staff # 102 was made aware of the issue on March 31, 2014.
The licensee did not ensure that equipment, such as assistive devices and positioning aids were kept in good repair. [s. 90. (2) (b)]

2. The licensee did not ensure that procedures were implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.
On March 31, 2014, Inspector # 158 observed that the taps in 4/4 residents' rooms/bathrooms had a rust/black residue present at the base, where it sits on the sink.
The Inspector noted that caulking at the base of 4/4 toilets were missing, cracked and appeared soiled.
The Inspector also noted that the toilets in 2 resident rooms were leaking on the floor and were slow to drain /fill after being flushed. [s. 90. (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 ensuring that equipment such as toilet seat bars and raised toilet seats are maintained in good repair and that plumbing fixtures, such as toilets and sinks are maintained and free of cracks and corrosion, to be implemented voluntarily.

WN #11: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in the implementation of the infection prevention and control program.
On March 31, 2014, Inspector # 158 observed that staff # 106 had finished assisting resident# 8012 with toileting and was observed to assist the resident back into bed. The staff member was wearing gloves, which were discarded after assistance was provided. The Inspector did not observe staff # 158 offer the resident any towel for washing hands, wipe down the commode or empty the commode's pail. The Inspector then observed that resident # 8002, who has severe cognitive impairment, came to sit on resident # 8012's commode and hold resident # 8012's hands.
It was identified by staff # 107 and 106 that resident # 8012 had Extended-spectrum Beta-lactamase producing Enterobacteriaceae (ESBL). It was also identified that commodes are to be wiped down by staff with "virox" Wipes" after use.
A review of resident # 8012's health care record, identified that the resident had been treated for ESBL, with an antibiotic, however, the tests showed that the resident remained positive for ESBL a month later. There were no further assessments completed. The home failed to ensure that all staff participated in the implementation of the infection prevention and control program. [s. 229. (4)]

2. Inspector #543 reviewed three residents' health care records in regards to TB screening. Resident # 02 who was recently admitted to the Home on had no information regarding TB history in the health care record. The "Immunization and Test Records" sheet had no data in regards to the resident's screening for tuberculosis. (Sheet was blank)
Resident # 03 who was recently admitted to the Home did not have a "Immunization and Test Records" sheet in the resident's chart, nor was information related to the screening history of tuberculosis available.
Resident # 01 was recently admitted to the Home. There was no information regarding the TB history in the health care record. The "Immunization and Test Records" sheet had no data in regards to the resident's screening for TB. (Sheet was blank)
Inspector #543 reviewed the home's Immunization Protocols Policy and it states that, the resident's immunization status is to be readily accessible on the resident's record and a two-step TB test is to be conducted within the first 14 days of admission for all residents except those who are known positive reactors.
In summary, there was no history of TB screening in the three residents' health care records. Subsequently, three residents who were recently admitted to the home were not screened for tuberculosis within 14 days of admission. [s. 229. (10) 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 ensuring that residents are screened for tuberculosis within 14 days of admission and that the status of resident # 8012 infection be determined so that staff are aware of any specific precautions to take, when providing care, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On March 27, 2014, Inspector # 544 and # 158 observed staff # 102 administering resident #8005's medication in a hallway. The Inspectors observed that staff # 102 raised the resident's shirt and administered the medication in the resident's abdomen in the hallway, while other staff and residents walked by. The licensee did not ensure that every resident's right to be afforded privacy in treatment and in caring for his or her personal needs was respected. [s. 3. (1) 8.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that a clothes closet was provided for every resident in the resident's room.
It was identified in a letter received by the Ministry that resident clothes closets are shared. On March 31, 2014, Inspector # 158 observed that clothing belonging to 2 residents (resident # 8011 and resident # 7994) were in one closet.
It was observed by Inspector # 544 that resident # 7992 clothing was in a closet in the storage room and not in the resident's bedroom.
The licensee did not ensure that a clothes closet was provided to three residents in the residents' bedrooms. [s. 12. (2) (f)]

WN #14: 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 did not 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.
Inspector # 544 reviewed resident # 7989's care plan and it was identified under bathing and shampooing that the resident is bathed twice weekly.
Inspector # 544 reviewed the resident's "Activities of Daily Living" "tick off sheet" and the bath Shift Notes. It was noted that only one bath was provided to resident # 7989 during the one week. Refusal of a bath was not documented. [s. 33. (1)]

2. Inspector # 544 reviewed the resident bath list and the "bath shift notes" and found that there were no bath shift notes for nine days.
It was confirmed by staff # 109 that the notes were not present in the binder.
In reviewing the ADL care and services in the resident's "tick list", the tub/shower/shampoo section, in 3/4 residents' records were blank.
The health care records, which included the "bath shift notes" and the "tick list" for resident # 7979 and # 8023 were reviewed.
It was noted that only one bath was provided to resident # 7979 during one week.
The licensee did not 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. [s. 33. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. It was identified in an interview with resident # 7989's Substitute Decision Maker (SDM) that for approximately a month, the resident has been having problems with their teeth. The SDM stated to Inspector # 158 that resident # 7989 had a recent dental appointment and is waiting for a date for teeth extractions.
The homes' policy dated June 2010 CN-S-13-1 states under interventions #3, that "Oral care to be provided at a minimum, twice per day with AM and PM care and as required to maintain clean teeth and mouth. Residents are encouraged to do this for themselves but staff to assist either verbally or physically, if resident is not able."
Inspector # 544 reviewed resident 7989's health care record, which included, progress notes, assessments, care plan, and "Activities of Daily Living " tick sheets.
As per the progress notes, the resident is presently receiving an analgesic to manage the dental pain, while waiting for a future dental appointment for the teeth extractions.
The MDS assessment completed recently, identified, that resident # 7989 who has dementia and is unable to follow direction, is dependent on staff for care and services, and requires assistance to brush their teeth.
Resident # 7989's care plan indicates "encourage resident to assist with cleaning their teeth q am and q pm; the resident needs to be taken into the bathroom or set up at bedside with toothbrush and toothpaste and supervised and given visual cues to complete the task."
Inspector # 544 noted that according to the tick sheets, the resident did not receive oral/mouth care twice a day 7 out of 31 days in March, 2014. (documentation not present)
The licensee failed to ensure that the resident of the home received oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening and the physical assistance or cuing to help a resident who cannot brush his or her own teeth. [s. 34. (1) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a resident at risk of altered skin integrity received a skin assessment upon any return from hospital.
On April 2, 2014, Inspector # 158 reviewed the home's wound care policy, which states, that upon any return from hospital, a resident is assessed, using a MDS Skin/Risk Assessment (MDS version).
Resident # 7971 was transferred to the hospital for assessment of abdominal pain. It was further documented that when the resident returned from hospital later that day, the resident sustained a skin tear.
On April 2, 2014, Staff # 110 stated to the Inspector that skin assessments are conducted when the resident returns from hospital and when altered skin integrity is known.
Resident # 7971 health care record was reviewed and there was no indication that a skin assessment was completed when the resident returned from hospital as indicated in the home's policy ("any return" from hospital). [s. 50. (2) (a) (ii)]

2. Resident # 7994 was admitted to the hospital returned to the home five days later. The home's wound care policy states that upon any return from hospital, a resident is to be assessed, using a MDS Skin/Risk Assessment (MDS version).
Resident # 7994 health care record was reviewed and although, resident # 7994 currently did not have an open area, it was identified in the plan of care that, the resident's skin is at a high risk to break down without preventative interventions in place. The inspector reviewed the assessments as well as the resident's chart and did not find that a skin assessment was completed when the resident returned from hospital, as indicated in their policy ("any return" from hospital).
The licensee did not ensure that resident # 7994, who was at risk of altered skin integrity received a skin assessment upon his return from hospital. [s. 50. (2) (a) (ii)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Findings/Faits saillants :

1. The licensee did not ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week.
On April 2, 2014, Inspector # 544 interviewed staff # 111, who verified that the nutrition manager, works 29 hours bi-weekly or 14.5 hours a week.
This was confirmed by the Administrator. According to the calculations "M" for the size of the home, the nutritional manager should be working 15.36 hours a week.
The licensee did not ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. [s. 75. (3)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).
(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Findings/Faits saillants :

1. The licensee did not ensure that either a physician or a registered nurse in the extended class conducted a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produced a written report of the findings of the examination.
Inspector # 158 noted that the record of annual physical examinations completed by the physician was missing in 15/15 residents' health care records.
Inspector # 158 reviewed 15 residents' health care records, which included 5 newly admitted residents and there were no written reports of annual physical examinations.
The Inspector spoke with staff # 102, who confirmed that the annual examinations have not been completed for 10 residents, as well as 5 new admissions. [s. 82. (1) (a)]

WN #19: The Licensee has failed to comply with LTCHA, 2007, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. Inspector #543 reviewed resident #8012's health care record in regards to ESBL policy and procedures. The resident's record had laboratory results for ESBL testing which identified that ESBL was present. No further testing was noted in the resident's health care record after that date. Inspector # 543 confirmed with the physician that no further testing was ordered.
Resident # 8012 is not on any isolation precautions for ESBL at this time, which was also confirmed by physician.
Inspector #543 reviewed the home's Policy-Antibiotic-Resistant Organism (ARO) and the policy states; precautions to be used for ARO-ESBL are routine and contact practices. The policy also stated that in order to discontinue isolation precautions, a minimum of three successive cultures with at least one culture taken three months after the last positive culture.
There are no measures in place to prevent the transmission of infection. [s. 86. (2) (b)]

WN #20: 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,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were implemented to ensure that residents' lost clothing and personal items are located.
It was identified by three different residents, that they had missing clothing, which have not been located.
The home does have a process of labeling resident clothing as part of their lost clothing process. Staff # 112 identified that there is a heat stamp labeler, which is used by staff to label resident clothing. The laundry aide checks the labels and re-labels, when needed. (labels are loose or falling off)
Staff identified that recently, the labels have been difficult to adhere and that the "magic marker" markings fade. The staff member identified that when they are unsure of who the clothing belongs to, they will bring the piece to staff and ask them.
It was identified in the latest Resident Council minutes that residents' request that labels be re-attached because labels on the clothing were falling off.
On April 1, 2014, Inspector # 158 conducted a random survey of the labels on resident's clothing (which were in their cupboards). It was noted that 20/20 labels on residents' clothing were missing, frayed and curling, or had faded and unreadable names written.
The licensee did not ensure that the home's process of lost clothing, which incorporates labeling of residents' clothing was implemented. [s. 89. (1) (a) (iv)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 21 day of May 2014 (A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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.

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
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Bureau régional de services de Sudbury
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Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : KELLY-JEAN SCHIENBEIN (158) - (A1)

Inspection No. / No de l'inspection : 2014_140158_0005 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : S-000010-14 (A1)

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

Report Date(s) / Date(s) du Rapport : May 21, 2014;(A1)

Licensee / Titulaire de permis : 675412 ONTARIO INC
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

LTC Home / Foyer de SLD : NORTHVIEW NURSING HOME
77 RIVER ROAD, P.O. BOX 1139, ENGLEHART, ON, P0J-1H0

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. 20

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : BRENDA SIMPSON

To 675412 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall ensure that all mattresses fit securely on each resident's bed frame and that an annual inspection is conducted by the maintenance staff to update the condition of any accessible asbestos containing materials within the building and that a report of this annual inspection is completed.

Grounds / Motifs :

1. An environmental consulting firm engaged by the home identified that asbestos containing material was present in the home. As part of the firm's recommendations, it was identified in a letter to the home, that the Administrator needs to ensure that an annual inspection is conducted by the maintenance staff to update the condition of any accessible asbestos containing materials within the building and that these inspections should occur in March of each year. The Asbestos Management Program book was reviewed by Inspector # 158 and no documented inspections were noted. The Health and Safety Committee's lead and the Administrator identified that inspections are done monthly, however there is no supporting documentation. (158)

2. The Inspectors observed that mattresses were not securely fitting 13/13 residents' bed frames.
The Administrator provided Inspector # 158 with the November 2013 mattress/bed survey, conducted an outside company. The survey identified that replacement of 17 mattresses was required related to the potential of entrapment in zone 2 and 4. The survey also identified that one of the newer electric beds had a mattress, which did not fit the frame and could cause a potential entrapment in zone 7.
On April 3, 2014, Inspector # 158 and the Environmental Service Manager toured the home to inspect the bed frames and mattresses, which were in use by residents. It was noted that the "bed rolled edged" mattresses did not fit in either the older style "manual" bed frame or in the bed frames, which were purchased in 2010. It was noted, as well, that three of the newly purchased beds (2010) did not have the wire at the end of the frame, which would keep the mattress in place. The older beds had plastic brackets at the ends of the frame, which would keep a mattress in place, however, the brackets on 2 bed frames were broken.
It was noted during this tour and coupled with the identified November 2013 bed/mattress survey, that 26 of the 48 residents, who reside in the home have mattresses, which do not fit the bed frame and pose a potential risk of injury, including possible entrapment in zones 2, 4 and 7.
The licensee did not ensure that the home is a safe and secure environment related to mattresses which do not securely fit bed frames for residents. (158)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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.

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

Jul 15, 2014(A1)

REVIEW/APPEAL INFORMATION

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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.

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

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 20

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.

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

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

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

Issued on this 21 day of May 2014 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : KELLY-JEAN SCHIENBEIN - (A1)

Service Area Office / Bureau régional de services : Sudbury