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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 8, 2014	2014_201167_0010	H-000298-14	Resident Quality Inspection

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5

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

MARILYN TONE (167), BERNADETTE SUSNIK (120), CATHY FEDIASH (214), JENNIFER ROBERTS (582), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): March 17, 18, 19, 20, 24, 25, 26, 27, 28, 31 and April 1, 2014.

The following inspections were completed simultaneously with this Resident Quality Inspection and will be included in this report:
Complaint Logs: #H-000732-13, H-000043-14, H-000113-14, H-000343-14, H-000255-14 and Critical Incident Logs # H-000225-14 and H-000037-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Food Service Manager, Assistant Director of Care (ADOC), Resident Assessment Instrument Coordinator (RAI Coordinator) Recreation Manager, Staffing Scheduler, Maintenance Manager, registered staff, personal support workers (PSWs), residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed resident care and meal service, reviewed the health files for identified residents, relevant policies and procedures, training record, employee files, family and residents' council minutes, other relevant reports and investigation notes completed by the home.

The following Inspection Protocols were used during this inspection:

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

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
2. Every resident has the right to be protected from abuse. 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:
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. [LTCHA s.3(1)2] was previously issued as a VPC in April 2013 and August 2013 and as a Compliance Order in December 3013.

The licensee did not ensure that resident's rights were fully respected and promoted when resident #002 was not protected from abuse

It was reported on an identified date in 2013, that a staff member verbally and physically abused resident #002. [s. 3. (1) 2.]

2. The licensee did not ensure that the right of residents at the home to be afforded privacy was fully respected and promoted.

Privacy curtains in resident rooms did not completely enclose the beds. A ceiling mounted lift track was installed in many rooms in 2013, dissecting many of the privacy curtain tracks. A gap of about 3-4 inches was apparent when curtains were tested. According to the maintenance manager, magnets were once attached to the curtains to keep the gap closed. However no magnets were found attached to curtains. [s. 3. (1) 8.]

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. 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. [LTCHA s.5] was issued as VPC in October 2012.

The licensee did not ensure that the home was a safe and secure environment for its residents during the inspection conducted in March 2014.
A) The shower room located in the 200 wing was not designed to allow water to adequately drain away into the drain. After running the shower wand for 1 minute, a pool of water had accumulated and was beginning to climb up over the raised flooring where it would eventually spill out into the corridor. The pooling water was observed to

be trickling very slowly into the drain. Staff were observed on several days using flannel blankets to create a dam or barrier around the shower area where residents are seated to keep it from spilling out into the hall. Management provided staff with a squeegee to push the water into the drain once showering had been completed. However during showering, staff and residents would be standing in a pool of water which is a safety concern for both residents and staff.

B) A table (large enough to accommodate 2 chairs) was left at the end of the corridor outside an of an identified resident room in March 2014. When personal support workers were questioned about the reason, they stated that visitors will often use it for snacks when visiting with residents. Staff identified that no portable over bed tables with wheels were available, however management staff identified that at least five were in storage. Objects such as tables in corridors cause obstructions for residents and are a safety hazard when having to evacuate during a fire or other emergency.

C) An unsafe raised toilet seat was identified on a toilet in a resident's room. The seat was very loose and did not have any tightening adjustments.

D) Electrical and television cable cords were identified sitting loosely on the floor in many resident rooms. The cables were not secured around the perimeter of the room or tied off in any way to keep them from entangling around other objects. Staff and residents have the potential of tripping or getting caught on these cords when working around the bed area. Two identified rooms were of particular concern as a modem was found on the floor along with multiple cords in both rooms.

E) Badly damaged wardrobe surfaces were observed in two resident rooms. The surfaces were so rough and splintered that they could not be cleaned. The furniture appeared to belong to the residents which is required to be evaluated for condition on a regular basis as would home-owned furniture.

F) Over bed lights were being used as shelving, with vases, picture frames and other objects stored on top of them in identified rooms. The administrator reported that these objects have been removed in the past however family members, residents and possibly staff continue to replace the items back onto the lights despite warnings.

G) Ceiling lifts installed in multiple resident rooms were observed to have spreader bars hanging down at shoulder level in such a manner that staff and residents trying to gain access to their closet or night table would be hit in the head. The spreader bars

were not retracted to their highest position.

H) A very loose bed rail was observed on a resident's bed. The resident reported that staff apply the rail for the resident when they are in bed nightly.

I) It was observed on an identified date during this inspection, in the hallway of Wing 100 that a hacksaw was laying on the hand rail that is used by residents. Contractors were working in a resident's room on the unit and left the hacksaw. This was brought to the contractor's attention by the inspector immediately and the hacksaw was removed from the handrail.
It was observed the next day in the hallway of Unit 200 that a hacksaw was laying on a box outside resident's rooms in the hallway. Contractors were working in a resident's room on the unit. This was immediately brought to the attention of the Maintenance Co-ordinator and the Administrator who confirmed this was a hazard to the residents. [s. 5.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. The infection prevention and control program did not include measures to prevent the transmission of infections. Measures were not instituted to ensure that the following were addressed:

Personal hygiene products are not being stored properly. Bar soap was noted in identified resident washrooms sitting on communal metal soap dishes. Numerous vanity tops were observed to have a metal soap dish mounted to the side of the vanity

which were shared by four residents. Residents did not have their own soap dishes or containers in which to store the soap. Roll-on deodorants, combs and hair brushes without resident names were observed to be stored in all tub rooms. Infection control prevailing practice is to ensure that hygiene products are returned to the resident and stored in their own designated drawer, closet, container or bag after each use and not in a communal space. In shared resident washrooms, these products were also identified to be sitting out on vanity tops unlabeled instead of within resident's drawers. [s. 86. (2) (b)]

2. The home's policy CN-C-21-1 dated May 2011 stated that the tub is to be rinsed, surfaces cleaned with disinfectant (allow for contact time) and rinsed. The policy does not address the differences between the ARJO tubs and the pedestal tubs (ARJO tubs have a disinfectant dispensing system built into the units) and the policy is missing information about the type of disinfectant, how long to apply the disinfectant, and whether the tub is to receive a physical scrubbing.
A low level disinfectant called AIRX44 was identified in all tub rooms. ARJO tub cleaning instructions state that the disinfectant is to be scrubbed around the surface, allowed to sit for 10 minutes and then rinsed. ARJO disinfectants provide 800 p.p.m. of an active ingredient to kill organisms whereas the AIRX44 disinfectant is approximately 400 p.p.m. AIRX44 disinfectant is applied manually by hand via an aerosol spray bottle and is inconsistently applied as opposed to using the tub's dispensing system which is applied via a hand wand and the solution is dispensed in the form of a liquid stream.

Staff are not able to wash and disinfect personal care articles such as wash basins and bed or slipper pans when necessary. Wash basins are considered to be class 1 medical devices and can be semi-critical depending on how they are used. Basins can become heavily contaminated when used for incontinence cleanup, indwelling catheter care and emesis collection and if not cleaned properly become a vehicle in the spread of disease causing organisms. Staff reported that the basins were rinsed and sprayed with a disinfectant called AIRX44 and wiped out with paper towel in the resident's washroom after use. Signage was observed to be posted in some washrooms identifying this procedure. However, they are not able to submerge them for deep cleaning when necessary.

Large washbasins were observed hanging on walls in resident washrooms. Many were noted to be covered in dust over a 3 day period in identified washrooms from a lack of regular use and inappropriate storage methods. Soap scum was observed on

basins in identified washrooms. The basins provided were too large to be properly submerged for deep cleaning in any of the home's available sinks. The home's policies and practices related to the current handling of soiled personal care articles does not address how they will be deep cleaned when necessary to remove residues that cannot be removed by daily spraying and wiping.

According to the home's policy CN-C-21-1, staff are required to wash and rinse the basin, but the policy does not state where this activity is to take place. There are no details about the type of disinfectant to use and how it is to be applied. The policy had not been updated but it also is missing a component related to deep cleaning when necessary of items in a sink, submerged.

Soiled utility rooms in each wing were observed to be structurally insufficient in size to accommodate the cleaning and disinfection process of personal care articles such as wash basins and bed pans. These rooms were equipped with a small hand sink and a hopper, neither of which can be used for cleaning purposes. A sign posted in the room above the hopper instructed staff to "rinse and use AirX44". A larger soiled utility room was identified at the 200/500 wing intersection which could support the installation of a large sink in which to deep clean and process basins and slipper pans. This option was discussed with the infection control designate. [s. 86. (2) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must 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. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

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

Findings/Faits saillants :

1. The licensee did not ensure that the home's policies, procedures and protocols were complied with in respect to the organized pain program required under sections 8 to 16 of the Act and under section 48 of this Regulation.

The home's policy related to Pain Management and a memorandum provided to staff by the DOC in December 2013 directs registered staff to use the "PACSLAC" form to assess pain for the cognitively impaired residents and the "Pain Assessment Tool for the Cognizant" for the residents who are not cognitively impaired.
The policy and the memorandum directed staff to complete these assessments on admission, re-admission, when changes occur and quarterly.

A) A review of the clinical record for resident #705 indicated that they experienced moderate pain on a daily basis and received routine analgesics. According to the Resident Assessment Instrument Minimum Data Set completed for the resident in 2014, under RAP Pain, resident #705 had changes made to the amount of analgesic medication to be received by the resident three times during the previous two months. Interviews conducted with registered staff, confirmed that no Pain Assessment Tool had been completed for this resident quarterly or with any changes, as required by the home's pain policy and memorandum from the DOC.

B) During a review of the health file for resident #661, it was noted that the resident was taking analgesic medication to control their pain on a regular schedule and also took some breakthrough medication for pain. It was also noted that no quarterly pain assessments completed for the resident could be found. Registered staff interviewed confirmed that no pain assessments were completed for the resident.
- During interviews with a registered staff they indicated that these assessments were to be completed by the RAI Co-ordinator.
- During an interview with the RAI Co-ordinator, they confirmed that they were not expected to complete these pain assessments and are only responsible for the quality portion of documentation related to pain.
- During an interview with the DOC they confirmed that registered staff have received training related to the use of the above forms for assessment of pain and that they were expected to complete them.
- Registered staff did not comply with the home's policy and procedure related to assessment of resident pain. (167)

C) Resident #640 was identified as having chronic pain and received regular analgesic medication to manage this pain.
- Resident #640 indicated during an interview that they continued to experience pain. According to the clinical records, the physician increased the residents regularly scheduled analgesic medication in 2013. The resident continued to complain of pain over the next two months. A review of the resident's health records indicate that the "Pain Assessment Tool" had not been completed related to the change in the residents pain. Further review of the resident's health records indicate that no quarterly pain assessments had been completed. It was confirmed by registered staff that the required pain assessments for resident #640 have not been completed. [s. 30.]

2. The licensee did not ensure that the home's policies, procedures and protocols were complied with in respect of the organized falls prevention and management program required under sections 8 to 16 of the Act and under section 48 of this Regulation.

The home's "Fall Prevention and Management Program policy" (CN-F-05-1)indicated that a Post Fall Evaluation was to be completed after each fall to determine changes in a resident's status.

A) A review of the clinical record for resident #004 indicated that the resident had sustained five falls over a four month period in 2013-2014. A review of the resident's clinical record indicated that a post fall evaluation had not been completed following four of the identified falls. An interview conducted with the ADOC confirmed that the post fall evaluations had not been completed for the four falls identified, as required by the home's fall policy.

B) A review of the clinical record for resident #753 revealed that the resident had sustained two falls in 2014. A review of the clinical record for resident #753 revealed that a Post Fall Evaluation had not been completed after the first fall that the resident sustained in 2014. An interview conducted with the DOC confirmed that the Post Fall Evaluation had not been completed for the identified fall. as required by the home's Fall Prevention and Management Program policy. [s. 30.]

3. The licensee did not ensure that the home's policy related to Meal Service and Delivery was complied with.

- The policy related to Meal Service and Delivery provided by the Nutrition Manager indicated that tray service should not be provided at the same time as regular dining service in order to ensure adequate supervision was available. The policy also indicated that trays would be set up and labelled with resident's name, diet and room number.
- During observation of tray service provided to residents on two separate occasions during the review, it was noted that the trays for residents receiving tray service were provided to residents at the beginning of the meal service.
- During an interview with the Nutrition Manager, they confirmed that tray service is provided to residents who eat in their rooms at the beginning of the dining room meal service. The Nutrition Manager indicated that on the south wing there were three staff designated to serve and provide assistance to residents who eat in their rooms. On

the extension wing there were two staff designated to serve and assist residents who eat in their rooms.
- It was noted during the observation of meal service that trays did not have labels indicating the resident's name, diet or room number as per the policy. [s. 30. (1)]

4. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.[s.30(2)]

During a review of the progress notes for resident # 646 it was noted that there were a number of concerns identified but no follow up documentation was found related to these concerns.
- On an identified date in 2013, the progress note indicated that that staff had noted that the resident had symptoms of a urinary tract infection and that it was noted in the calendar to obtain a urine specimen. There was no further follow up documentation in the progress notes related to whether the specimen was obtained or not or what the results were of the urine culture.
- On an identified date in 2014, the progress note indicated that the resident's had skin excoriation to an identified area and that a treatment was applied. There was no further follow up documentation related to this issue.
- On another identified date in 2014, the progress note indicated that an area of the resident's body was very red but staff were unable to check at that time as the resident was in their wheelchair. There was no further follow up related to this concern in the resident's progress notes. [s. 30. (2)]

5. A review of the plan of care for resident #004 on an identified date in 2014, including the progress notes and physician's orders, revealed that on an identified date in 2013 the attending physician was contacted and provided verbal authorization for a treatment to be provided to #004.
- A review of the progress notes for the resident revealed that there was no documentation to indicate that the Power of Attorney (POA) for resident #004 was notified and consented to the intervention.
- An interview with a member of the registered staff confirmed that documentation of consent for an intervention should have been recorded in the progress notes of a resident's health care record.
- The member of the registered staff verified that the POA for resident #004 was contacted and consent was obtained for the treatment, however, this was not documented in the health care record of resident #004. [s. 30. (2)]

6. An interview with resident #004's family in 2014, indicated that approximately one month prior, an incident had occurred in which the resident sustained an injury. A review of this resident's clinical records over the identified time frame did not identify any documentation in the clinical record of this incident having occurred. An interview conducted with the ADOC indicated that the home was informed by the family of the same incident and that no documentation in regards to the reporting of this incident had occurred. [s. 30. (2)]

7. Resident #640 was identified as having chronic pain and receives regular analgesic medication to manage this pain. According to registered staff, residents identified as having pain are assessed on a weekly basis and the level of pain is documented in the Medication Administration Records (MAR). It was noted in an identified month in 2014, the level of pain was not documented weekly as required four out of four times.
- During a review of the resident's clinical records, a partially completed Pain Assessment Tool was noted with no date and no signature documented. The level of pain was documented as zero however; it also indicated that the resident had "horrible" pain.
- It was confirmed by registered staff that the Pain Assessment Tool had not been completed and that the assessments documented had conflicting information.

B) On an identified date in 2013 resident #735 was complaining of pain described as a burning sensation. According to the clinical records, the registered nurse documented that staff on the next shift would be made aware and a sample of urine for culture and sensitivity would be collected as needed. There was no further documentation in the clinical records related to this occurrence of pain or the outcome of the urine sample. It was confirmed by registered staff that follow up documentation had not been completed. [s. 30. (2)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that when bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #661 was observed to be using one partial bed rail at the top of their bed.
- An assessment of the bed system related to entrapment risk completed in 2013 confirmed that the bed system failed the entrapment risk in one or more zones. The bed has not since been retested.
- Staff interviewed confirmed that the resident used one bed rail in bed to assist them with mobility.
- The plan of care for the resident indicated that the resident used one side rail in bed for positioning. Personal Assistive Safety Device (PASD).
- The home's policy and procedure related to use of PASD indicated that the Restraint/PASD Assessment which included evaluation of risk factors, alternatives considered and trialed was to be completed upon admission, quarterly and with a change in condition that impacted the use of the restraint/PASD.
- It was noted that in the care plan section of the resident's chart there was one "Restraint/PASD Assessment ", but it was not complete. The form did not indicate the type of PASD/Restraint being assessed and there were no dates found on the form or signatures for persons completing the form. The form was not completed to include areas related to whether the resident had the potential to try to climb over the rails, medications that might impact safety, side rail alternatives that had been tried, whether the side rails created more risk, fluctuations in cognitive status and many others that may be relevant to the assessment for entrapment risk.

B) On observation, resident #004's bed system was noted to have a special surface with two half rails in the upright position. It was noted that the resident's bed failed entrapment risk for more than one zone. There was no nursing assessment completed for bed entrapment in relation to the use of the air powered surface and two half rails. An interview conducted with the ADOC confirmed that no assessment had been completed (214). [s. 15. (1) (a)]

2. The licensee did not ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident bed systems in the home were evaluated for entrapment zones in 2013 by an external company. The results of the audit revealed that more than 80% of the beds failed one or more entrapment zones. The recommendation by the auditor was to replace aging mattresses, add mattress keepers, tighten rails and add bed rail end caps. Management staff for the home reported that some new mattresses were purchased, rail end caps added, rails tightened and mattress keepers added. However, since that time, beds have been re-arranged and relocated, mattress keepers have broken off or are still missing on some beds and rails have become loose. Using the audit results to locate the beds to verify compliance could not be completed, as the beds were no longer in rooms as originally identified. Mattresses that may have passed testing on a particular bed frame have since been moved onto other beds. Management staff did develop a method or system to ensure that bed frames and mattresses that passed entrapment zone testing remained together. During the inspection, numerous residents were identified to be sleeping in beds with both side rails in the raised position where the status of the entrapment compliance was unknown. Over 10 therapeutic surfaces were identified, which are of a design that makes them a high risk for entrapment due to their compressible nature. Residents were identified sleeping on these beds with one or both bed rails in the raised position in identified resident rooms. No bolsters, gap fillers or rail pads were observed to be in place to reduce entrapment zones between the rail and mattress. No other alternatives were instituted with respect to rail use. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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).

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

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

Findings/Faits saillants :

1. The licensee did not ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #004's plan of care for falls/balance identified that floor mats were to be placed beside the resident's bed and that the bed was to be placed in the lowest position. The resident's bed system was observed on on an identified date during the inspection, with the presence of the ADOC and it was noted that only one fall mat was placed beside the resident's bed and that the bed was not placed in the lowest position. The ADOC confirmed that two fall mats were to be in place and that the bed was to be in the lowest position. [s. 6. (7)]

2. The licensee did not ensure that staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had

convenient and immediate access to it.

The RAI Co-ordinator confirmed that the current practice in the home regarding resident's care plans was that they are updated electronically when changes occur and remain in the computer software system. Staff who provide direct care to a resident have access to the resident's kardex by the printed version placed in a binder at the nursing station and that the printed kardex is updated manually when changes occur.

A) A review of resident #004's printed kardex for falls/balance, did not identify fall interventions of a bed alarm in place; the residents bed to be in the lowest position and fall mats to be in place at the residents bedside and directed staff to see the care plan. An interview conducted with the ADOC confirmed that front line staff do not have access to the electronic care plans [s. 6. (8)]

3. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) A review of resident #004's clinical record indicated that on an identified date in 2014, the resident sustained an injury following a fall. A review of their plan of care did not identify the injury, the expected outcomes or the interventions required to care for the resident with the injury. Registered staff confirmed the plan of care was not updated when the resident's care needs changed upon return from the hospital. [s. 6. (10) (b)]

4. The licensee did not ensure that the plan of care for resident #705 was reviewed and revised when the resident's care needs changed.

In 2013, resident #705 was noted to be unable to be seated at the tables in the dining room and was unable to use over bed table in the dining room as an eating surface.
- The home's staff did try a number of interventions to try to accommodate seating for the resident in the dining room.
- The resident was also noted to refuse to go to the dining room at times for meals.
- It was observed that the resident now consistently eats meals in their room and the resident confirmed this.
- The plan of care for resident #705 was not reviewed and revised to indicate that the resident routinely eats their meals in their room. [s. 6. (10) (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 the ensure that a)the care set out in the resident's plan of care is provided to the resident as specified in the plan, b) staff and others who provide direct care to the resident are kept aware of the contents of the plan of care and have convenient access to it and c) the resident is reassessed and their plan of care reviewed and revised at least every six months and any other time when the resident's care needs change or care set out in the plan is no longer necessary or has not been effective., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee of the home did not ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

6 windows and 3 glass sliding patio doors were observed in March 2014 to be missing a restriction device to limit the opening of the window or door to a maximum of 15 cm. Windows in identified resident rooms and the large sliding glass patio doors located in the garden room, main lounge (100/200 wing area) and back lounge (500/600 wing area) were found unrestricted. The method of restricting the windows/doors has not been successful in each case, as standard screws were drilled into the metal frame of the window/door either at the bottom or both at the top and bottom. It appears that staff, residents or visitors have been able to remove these screws to allow the window/door to fully open. The management of the home had maintenance staff re-enforce the windows/doors with a different type of restriction device after being informed.[s. 16.]

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 window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The resident-staff communication and response system was not available in every area accessible by residents. Activation stations, which connect to the enunciator panel located at a nurse's station and alert staff that assistance is needed, were not equipped in 2 dining rooms or in the 3 available lounge spaces used by residents. [s. 17. (1) (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 the home is equipped with a resident-staff communication and response system that e) is available in every area accessible by residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee of the long-term care home did not ensure that the lighting requirements set out in the Table to this section were maintained.

A Sekonic Handi Lumi illumination light meter was used to measure various areas of the home such as resident bedrooms, bathrooms, common areas and corridors. Outdoor lighting conditions at the time of the inspection were overcast. The meter was held 0.8 meters above and parallel to the ground and held away from the body to avoid shadowing. Daylight affecting the meter could not be controlled for in all areas as window coverings were minimal or allowed for some seepage and therefore the readings may not be as accurate.

In corridors, measurements were taken between the ceiling flush mounted fluorescent light fixtures (luminaires) which were 2 feet by 2 feet in size as well as directly below them. The home consisted of 6 corridors, identified as wings 100 through to wings 600. In all 6 wings, the luminaires were spaced either 6, 8 or 10 feet apart, depending on the location of sprinkler heads and heat sensors. Lux levels below the luminaires were well above the required level of 215.28 lux, however the lux between two luminaires spaced 8 or 10 feet apart was between 50 and 125. The level of lux was not maintained at a consistent and continuous 215.28.

The lounge space located in the 500/600 area was equipped with 10 recessed pot lights (ceiling height approximately 10 feet) and 4 fluorescent ceiling mounted luminaires on a ceiling that was approximately 20 feet high. The natural day light could not be excluded as there were no window coverings. The lux directly under one pot light was 100. The lux under the fluorescent luminaires was 300. The lux level between the pot lights was 20. The lounge near the 100/200 wing was designed identically to the lounge in the 500/600 wing area and had the same types of luminaires and illumination levels. The minimum requirement is 215.28 lux.

The dining room located in the 500/600 wing area was equipped with 6 pot lights upon the entry section and the ceiling height was approximately 10 feet. The rest of the dining area had a higher ceiling with 5 fluorescent illuminaires. The natural day light could not be excluding during the measurements. The lux under the pot lights was 100 -175 (furthest point away from the windows). The corridor that wraps around the nurses' station in the 500/600 wing area was equipped with 8 pot lights with a lux of 100. The main nurse's station near the front entrance was also equipped with the same pot lights and illumination levels. The minimum requirement is 215.28 lux.

The resident rooms were equipped with several illuminaires, one at the entrance and two within the larger bedrooms. The illuminaires were ceiling mounted, round dome-type lights with opaque glass and they emitted a lux of 100. In an identified room, all

window coverings were drawn and all lights, including the over bed lights were turned on and when standing centrally in the room, the general lux was 20-50. [s. 18.]

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 lighting requirements set out in the Table to this section are maintained, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred shall immediately report the suspicion and the information upon which it is based to the Director: 1. Misuse or misappropriation of a resident's money.

A) According to the clinical record for resident #705, on an identified date in 2013, the resident reported to staff that in the last two weeks, they had an identified amount of money missing. A review of the submitted Critical Incident Report indicated that this incident was not reported to the Director, until the following day. The DOC confirmed that the report was not submitted immediately, as required.
- According to the clinical record for resident #705, on another identified date in 2013, the resident reported to several staff that another identified amount of money was missing from their room. A review of the submitted Critical Incident Report indicated that this incident was not reported to the Director, until four days later. The DOC confirmed that the report was not submitted immediately, as required.
- According to the clinical record for resident #705, on a third identified date in 2013, the resident reported to staff that they were missing an identified amount of money. A review of the submitted Critical Incident Report indicated that this incident was not reported to the Director, until the following day. The Administrator confirmed that the report was not submitted immediately, as required. [s. 24. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that if there are reasonable grounds to suspect that the following has occurred or may occur the licensee shall immediately report the suspicion and the information upon which it is based to the Director: Misuse or misappropriation of a resident's money, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) According to the clinical record, resident #735 had ongoing complaints of pain and received routine and as needed (PRN)analgesic medication to manage their pain. Resident #735 received PRN analgesic medication nine times in November, 2013, 21 times in December, 2013, 12 times in January, six times in February, and five times in March, 2014.
- The plan of care for resident #735 indicated that an increase in their pain medication was ordered on in April 2013 and that staff were to monitor for effectiveness and inform the physician if the changes were ineffective.
- According to the resident's clinical records, and confirmed by registered staff, there has been no reassessment related to the ineffectiveness of the medication intervention. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose., to be implemented voluntarily.

WN #12: 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).

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. The licensee has not ensured that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, procedures were not developed or implemented to ensure that there is a process to report and locate residents' lost clothing and personal items.

On an identified date in 2014, the laundry room was toured and a rack of overloaded unclaimed clothing items was observed. Laundry staff could not confirm how long the items had been hanging on the rack and could not identify which items were donated and which items belonged to residents currently residing in the home. The home has not adequately designed a process to locate residents' lost clothing. The clothing hanging on the lost and found rack is difficult to search through and donated and lost items were not separated out. According to the activation manager, the lost clothing is put in a box and put out for families and residents 3 times per year. No written procedures for this process was available and no procedures were available that dealt with how long lost items are kept, when they are displayed, how they are separated form donated items, how donated items are managed.

Residents reported to inspectors that they had missing clothing items which were never returned. The residents confirmed that the items were labeled, that they complained to personal support workers, were not given a form to complete and never heard back about the course of action anyone took. The home's policy (without an identifying policy #) requires staff to complete a form with the details of the clothing item and a summary of what was done to try and locate the item. The blank forms were available to all staff in the soiled utility rooms on the bulletin boards. If the item cannot be located, the form is to be given to the administrator for further follow-up. This was not done for the three residents who complained about missing items. No monitoring of this program in general has been conducted to determine if staff are following the procedures. [s. 89. (1) (a) (iv)]

2. As part of the organized program of laundry services under clause 15 (1) (b) of the Act, the licensee of a long-term care home did not shall ensure that linen is maintained in a good state of repair. Linen includes pillows which were found to be poor condition with cracked exterior surfaces in identified resident rooms. [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 that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, procedures are developed or implemented to ensure that there is a process to report and locate residents' lost clothing and personal items and to ensure that linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odour, to be implemented voluntarily.

WN #13: 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee did not ensure that there is in place a hand hygiene program in accordance with prevailing practices with access to point-of-care hand hygiene agents.

Point-of-care hand hygiene agents, in accordance with prevailing practices, are required to be provided where care is provided, generally inside resident bedrooms. Hand hygiene agents were not made available in resident rooms in the 500 and 600 wings (an area for residents with cognitive impairments). The reason provided for not installing them in these rooms was the fear that residents would ingest the product. However, the product is encased in a bag inside of a holder which makes it very difficult to ingest adequate amounts to cause injury. [s. 229. (9)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none with with prevailing practices, and with access to point-of-care hand hygiene agents, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee did not report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

A) According to the clinical record, on an identified date in 2013, resident #705, informed staff they were missing an identified amount of money. The licensee submitted a Critical Incident to the Director. The agent of the Director requested the licensee to amend the Critical Incident upon completion of the home's investigation. A review of the home's submitted critical incidents as well as an interview conducted with the DOC, confirmed that the licensee did not conduct an investigation and did not submit the results of the investigation to the Director, as required.
- According to the clinical record, on another identified date in 2013, resident #705, informed staff they were missing an identified amount of money. The licensee submitted a Critical Incident to the Director. The agent of the Director requested the licensee to amend the Critical Incident, indicating the outcome of the in-home investigative process and to also provide alternate options and/or interventions that have been discussed with the resident and/or Power of Attorney, to prevent recurrence. A review of the home's submitted critical incidents as well as an interview conducted with the DOC, confirmed that the licensee did not conduct an investigation and did not submit the results of the investigation to the Director, as required.
- According to the clinical record, on a third identified date in 2013, resident #705, informed staff that they were missing money. The licensee submitted a Critical Incident to the Director. The agent of the Director requested the licensee to amend the Critical Incident to include how the home had investigated regarding the missing money, other than contacting police and the long term plan to prevent re-occurrence. A review of the home's submitted critical incidents as well as an interview conducted with the DOC, confirmed that the licensee did not conduct an investigation and did not submit the results of the investigation to the Director, as required. [s. 23. (2)]

WN #15: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

An interview conducted during the inspection with the Council President, indicated that the meal and snack times had not been reviewed by the Residents' Council. A review of the residents' council minutes from January 2013 till present, and confirmed by the Director of Therapeutic Recreation Services, confirmed that the meal and snack times had not been reviewed by the Resident's Council. [s. 73. (1) 2.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results.

An interview conducted with the Family Council lead during this inspection, indicated that the Family Council was not sought out for their advice in developing and carrying out the Satisfaction Survey. The Administrator confirmed that the advice of the Resident's Council and the Family Council is not obtained in developing and carrying out the Satisfaction Survey as the survey is designed by the Corporation, forwarded to the home and that the home sends out the survey via mail. [s. 85. (3)]

WN #17: 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. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours. The tub room located in the 500 wing had strong lingering odours on two identified days during the inspection after being mopped several times. Visible urine could not be detected but is suspected of having seeped down under the baseboards, into the exposed heater or under the tub where the floor appeared soiled and was more difficult to clean with just a mop. [s. 87. (2) (d)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure that at least quarterly, there was a documented reassessment of the resident's drug regime.

During a review of the health file for resident #661, it was noted that there was no quarterly medication review completed for the last quarter on their health file.
- During an interview with a registered practical nurse, they confirmed that no three Month Medication Review (3MMR) was on the resident's health file and indicated that it was still awaiting completion by the physician.
- The most current (3MMR) was last signed by the physician in November 2013 and covered the period of time between November 1, 2013 until January 31, 2014.
- There was no current 3MMR completed for the time period between February 1, 2014 and April 30, 2014. [s. 134. (c)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 207. Transfer list

Specifically failed to comply with the following:

s. 207. (1) Every licensee of a long-term care home shall keep a transfer list consisting of,
(a) the names of the residents of the home who are requesting a transfer from preferred accommodation in the home to basic accommodation in the home; O. Reg. 79/10, s. 207 (1).
(b) the names of the residents of the home who are requesting a transfer from private accommodation in the home to semi-private accommodation in the home; O. Reg. 79/10, s. 207 (1).
(c) the names of the residents of the home who are requesting a transfer from basic accommodation in the home to semi-private accommodation in the home; O. Reg. 79/10, s. 207 (1).
(d) the names of the residents of the home who are requesting a transfer from basic accommodation in the home to private accommodation in the home; O. Reg. 79/10, s. 207 (1).
(e) the names of the residents of the home who are requesting a transfer from semi-private accommodation in the home to private accommodation in the home; O. Reg. 79/10, s. 207 (1).
(f) the names of residents of the home who are requesting a transfer from a bed that is closing within 16 weeks to another bed in the home; and O. Reg. 79/10, s. 207 (1).
(g) where the home has a unit or area within the home that is primarily engaged in serving the interests of persons of a particular religion, ethnic origin or linguistic origin, the names of residents,
(i) who are requesting a transfer to the unit or area or out of the unit or area and based on the class of accommodation requested, and
(ii) who are in the unit or area and are requesting a change in class of accommodation within that unit or area. O. Reg. 79/10, s. 207 (1).

s. 207. (2) The licensee shall place the name of a resident on the transfer list referred to in subsection (1) when the request for a transfer is received. O. Reg. 79/10, s. 207 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home kept a transfer list consisting of the names of the residents of the home who had requested a transfer from basic accommodation in the home to private accommodation in the home.

An interview conducted with resident #705 indicated that in 2013, the resident requested a transfer from their basic accommodation in the home to a private accommodation in the home. A review of this resident's clinical record also indicated that in 2014, the resident continued to express their dissatisfaction with their accommodations and requested to be on a list for a private room. An interview conducted with the ADOC confirmed that the resident had made this initial request in 2013 and that the home did not add these request's to their transfer list as the home had not implemented a transfer list of resident requesting transfers. [s. 207. (1) (d)]

2. The licensee did not ensure that the name of a resident was placed on the transfer list when the request for a transfer was received.

An interview conducted with resident #705 indicated, that in 2013, the resident requested a transfer from their basic accommodation in the home to private accommodation in the home. A review of this resident's clinical record also indicated that in 2014, the resident continued to express their dissatisfaction with their accommodations and requested to be on a list for a private room. An interview conducted with the ADOC confirmed that the resident had made this initial request in 2013 and that home did not add this request or any subsequent requests to the transfer list at the time the requests were received and as a result, two private accommodations had become available in the home from during the time period that were not offered to this resident. [s. 207. (2)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home. O. Reg. 79/10, s. 305 (3).
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents. O. Reg. 79/10, s. 305 (3).

Findings/Faits saillants :

1. The licensee commenced minor alterations to the home without first receiving the approval of the Director.

During the inspection in March 2014, inspectors observed contractors working in resident rooms installing additional electrical outlets above their beds. In order to complete the task, the workers moved residents beds away from the wall while residents were still lying in their beds. The work created some dust and noise. 22 of the rooms were slated to have this work completed over the course of 3-4 days. According to the home's operational plan, provided after the work had already started, residents were to be out of their rooms when work was being completed in their rooms. A worker reported to an inspector that they did not have experience working inside of a long term care home where seniors have cognitive impairment. The home's plan summarizes that the contractors would report to the safety-coordinator and administrator for safety orientation and review of thelicensee's general safety guidelines and policy. This was not completed according to management of the home. [s. 305. (3)]

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

Issued on this 24th day of April, 2014

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

Marilyn Love

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

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. 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) :	MARILYN TONE (167), BERNADETTE SUSNIK (120), CATHY FEDIASH (214), JENNIFER ROBERTS (582), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2014_201167_0010
Log No. / Registre no:	H-000298-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 8, 2014
Licensee / Titulaire de permis :	MARYBAN HOLDINGS LTD 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	OAKWOOD PARK LODGE 6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LeAnne Ryan

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

To MARYBAN HOLDINGS LTD, 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)

Linked to Existing Order / Lien vers ordre existant: 2013_201167_0038, CO #001;

Pursuant to / Aux termes de :

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

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

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

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

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

independent opinion with regard to any of those matters, and

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

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

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

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

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

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

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

i. the Residents' Council,

ii. the Family Council,

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

iv. staff members,

v. government officials,

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

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

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

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

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

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

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

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

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

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

Order / Ordre :

The licensee shall ensure that all residents at the home are protected from abuse.

Grounds / Motifs :

1. The licensee did not ensure that resident's rights were fully respected and promoted when resident #002 was not protected from abuse.

It was reported in 2013, that on an identified date in 2013, a staff member verbally and physically abused resident #002. The incident was observed and reported by a co-resident. (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 22, 2014

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. 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:
1. Ensure that all bed rails are tight-fitting and in good repair. Develop a preventive maintenance program that includes bed side rails as part of a routine check along with other bed components. The inspections are to be documented.
2. Ensure that all contractors are oriented to the licensee's general safety policies regarding resident safety before starting work in the long term care home.
3. Ensure that the shower located in the 200 wing drains adequately without staff intervention.
4. Secure all cording in resident rooms so that it does not pose a tripping hazard for staff and residents.
5. Ensure that all resident-owned furniture is assessed prior to admittance to the home and that it is assessed regularly thereafter for condition. Furniture in identified resident rooms that is in poor condition is to be removed or the resident is to have it repaired/resurfaced.
6. Objects are to be removed from all over bed lights and a routine monitoring program is to be developed to ensure lights remain free of objects.
7. All ceiling lift spreader bars are to be retracted to their highest position (just under the charger which is attached to the track) so that they do not pose an injury potential for staff and residents.

Grounds / Motifs :

1. The licensee did not ensure that the home was a safe and secure environment for its residents during the inspection conducted in March 2014.

A) The shower room located in the 200 wing was not designed to allow water to

adequately drain away into the drain. After running the shower wand for 1 minute, a pool of water had accumulated and was beginning to climb up over the raised flooring where it would eventually spill out into the corridor. The pooling water was observed to be trickling very slowly into the drain. Staff were observed on several days using flannel blankets to create a dam or barrier around the shower area where residents are seated to keep it from spilling out into the hall. Management provided staff with a squeegee to push the water into the drain once showering had been completed. However during showering, staff and residents would be standing in a pool of water which is a safety concern for both residents and staff.

B) A table (large enough to accommodate 2 chairs) was left at the end of the corridor outside of an identified room during this inspection conducted in March 2014. When personal support workers were questioned about the reason, they stated that visitors will often use it for snacks when visiting with residents. Staff identified that no portable over bed tables with wheels were available, however management staff identified that at least five were in storage. Objects such as tables in corridors cause obstructions for residents and are a safety hazard when having to evacuate during a fire or other emergency.

C) An unsafe raised toilet seat was identified on a toilet in an identified resident room. The seat was very loose and did not have any tightening adjustments.

D) Electrical and television cable cords were identified sitting loosely on the floor in many resident rooms. The cables were not secured around the perimeter of the room or tied off in any way to keep them from entangling around other objects. Staff and residents have the potential of tripping or getting caught on these cords when working around the bed area. Two identified resident rooms were of particular concern as a modem was found on the floor along with multiple cords in both rooms.

E) Badly damaged wardrobe surfaces were observed in two identified resident rooms. The surfaces were so rough and splintered that they could not be cleaned. The furniture appeared to belong to the residents which is required to be evaluated for condition on a regular basis as would home-owned furniture.

F) Over bed lights were being used as shelving, with vases, picture frames and other objects stored on top of them in six identified resident rooms. The administrator reported that these objects have been removed in the past

however family members, residents and possibly staff continue to replace the items back onto the lights despite warnings.

G) Ceiling lifts installed in multiple resident rooms were observed to have spreader bars hanging down at shoulder level in such a manner that staff and residents trying to gain access to their closet or night table would be hit in the head. The spreader bars were not retracted to their highest position.

H) A very loose bed rail was observed on a resident's bed in an identified resident room. The resident reported that staff apply the rail for the resident when they are in bed nightly.

I) It was observed in the hallway of Wing 100 that a hacksaw was laying on the hand rail that is used by residents. Contractors were working in a resident's room on the unit and left the hacksaw. This was brought to the contractor's attention by the inspector immediately and the hacksaw was removed from the handrail.
It was observed the following day, in the hallway of Unit 200 that a hacksaw was laying on a box outside resident's rooms in the hallway. Contractors were working in a resident's room on the unit. This was immediately brought to the attention of the Maintenance Co-ordinator and the Administrator who confirmed this was a hazard to the residents.

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 12, 2014

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 :

LTCHA, 2007 S.O. 2007, c.8, 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
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Order / Ordre :

The licensee shall ensure that:
1. All tubs with a built-in disinfection system be operational and equipped with the manufacturer's disinfection product.
2. All pedestal tubs which do not have a built-in disinfection system, be provided with an automatic dispensing system that will dispense the appropriate amount of disinfectant and water through a hand held shower wand.
3. Cleaning procedures be developed or obtained from the dispensing system manufacturer for the tubs and posted for staff referral in all tub rooms. A written policy and procedure for tub cleaning and disinfection using the automatic dispensing systems shall be updated and available to all staff.
4. The soiled utility room located at the intersection of wing 200 and 500 be equipped with a deep sink large enough to accommodate and submerge the largest personal care device for the purposes of cleaning and disinfection. The hopper may be removed to accommodate the sink. An automatic disinfection dispensing system shall be installed next to the sink.
5. The policy and procedure regarding the cleaning and disinfection of personal care devices shall be updated to include the use of the room and associated sink and disinfection dispensing system.

Grounds / Motifs :

1. The home's policy CN-C-21-1 dated May 2011 states that the tub is to be rinsed, surfaces cleaned with disinfectant (allow for contact time) and rinsed. The policy does not address the differences between the ARJO tubs and the pedestal tubs (ARJO tubs have a disinfectant dispensing system built into the

units) and the policy is missing information about the type of disinfectant, how to apply the disinfectant, how long to apply the disinfectant, whether a brush is to be used and whether the tub is to receive a physical scrubbing. A low level disinfectant called AIRX44 was identified in all tub rooms. ARJO tub cleaning instructions state that the disinfectant is to be scrubbed around the surface, allowed to sit for 10 minutes and then rinsed. ARJO disinfectants provide 800 p.p.m of an active ingredient to kill organisms whereas the AIRX44 disinfectant is approximately 400 p.p.m. AIRX44 disinfectant is applied manually by hand via an aerosol spray bottle and is inconsistently applied as opposed to using the tub's dispensing system which is applied via a hand wand and the solution is dispensed in the form of a liquid stream.

Staff are not able to wash and disinfect personal care articles such as wash basins and bed or slipper pans when necessary. Wash basins are considered to be class 1 medical devices and can be semi-critical depending on how they are used. Basins can become heavily contaminated when used for incontinence cleanup, indwelling catheter care and emesis collection and if not cleaned properly become a vehicle in the spread of disease causing organisms. Staff reported that the basins were rinsed and sprayed with a disinfectant called AIRX44 and wiped out with paper towel in the resident's washroom after use. Signage was observed to be posted in some washrooms identifying this procedure. However, they are not able to submerge them for deep cleaning when necessary.

Large washbasins were observed hanging on walls in resident washrooms. Many were noted to be covered in dust over a 3 day period in identified resident washrooms from a lack of regular use and inappropriate storage methods. Soap scum was observed on basins in identified resident washrooms. The basins provided were too large to be properly submerged for deep cleaning in any of the home's available sinks. The home's policies and practices related to the current handling of soiled personal care articles does not address how they will be deep cleaned when necessary to remove residues that cannot be removed by daily spraying and wiping.

According to the home's policy CN-C-21-1, staff are required to wash and rinse the basin, but the policy does not state where this activity is to take place. There are no details about the type of disinfectant to use and how it is to be applied. The policy had not been updated but it also is missing a component related to deep cleaning when necessary of items in a sink, submerged.

Soiled utility rooms in each wing were observed to be structurally insufficient in size to accommodate the cleaning and disinfection process of personal care articles such as wash basins and bed pans. These rooms were equipped with a small hand sink and a hopper, neither of which can be used for cleaning purposes. A sign posted in the room above the hopper instructed staff to "rinse and use AirX44". A larger soiled utility room was identified at the 200/500 wing intersection which could support the installation of a large sink in which to deep clean and process basins and slipper pans. This option was discussed with the infection control designate.

The infection prevention and control program did not include measures to prevent the transmission of infections. Measures were not instituted to ensure that the following were addressed:

Personal hygiene products are not being stored properly. Bar soap was noted in identified resident washrooms sitting on communal metal soap dishes. Numerous vanity tops were observed to have a metal soap dish mounted to the side of the vanity which were shared by four residents. Residents did not have their own soap dishes or containers in which to store the soap. Roll-on deodorants, combs and hair brushes without resident names were observed to be stored in all tub rooms. Infection control prevailing practice is to ensure that hygiene products are returned to the resident and stored in their own designated drawer, closet, container or bag after each use and not in a communal space. In shared resident washrooms, these products were also identified to be sitting out on vanity tops, without labels.
(120)

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. General requirements

Order / Ordre :

1) The licensee shall prepare, implement and submit a plan to ensure that the home's policies, procedures and protocols with respect to the Falls Management and Pain Management and the policy related to the provision of Meal Service and Delivery at the home are complied with.
2) The plan shall also include identification of how the licensee will ensure that any actions taken with respect to a program including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The plan shall be submitted electronically to: Marilyn.Tone@ontario.ca by April 30, 2014

Grounds / Motifs :

1. The licensee did not ensure that the home's policies, procedures and protocols were complied with in respect to the organized pain program required under sections 8 to 16 of the Act and under section 48 of this Regulation.

The home's policy related to Pain Management and a memorandum provided to staff by the DOC in December 2013 directed registered staff to use the "PACSLAC" form to assess pain for the cognitively impaired residents and the "Pain Assessment Tool for the Cognizant" for the residents who are not cognitively impaired.
The policy and the memorandum directed staff to complete these assessments on admission, re-admission, when changes occur and quarterly.

A) A review of the clinical record for resident #705 indicated that they experienced moderate pain on a daily basis and received routine analgesic medication. According to the Resident Assessment Instrument Minimum Data Set, completed in March 2014, under RAP Pain, resident #705 had changes

made to the amount of analgesic medication ordered for them three times during the previous quarter. Interviews conducted with registered staff, confirmed that no Pain Assessment Tool had been completed for this resident quarterly or with any changes, as required by the home's pain policy and memorandum from the DOC.

B) During a review of the health file for resident #661, it was noted that the resident received analgesic medication to control their pain on a regular schedule and also took some breakthrough medication when required for pain. It was also noted that no quarterly pain assessments completed for the resident could be found. Registered staff interviewed confirmed that no pain assessments were completed for the resident.
- During interviews with registered staff, they indicated that these assessments were to be completed by the RAI Co-ordinator.
- During an interview with the RAI Co-ordinator, they confirmed that they are not expected to complete these pain assessments and are only responsible for the quality portion of documentation related to pain.
- During an interview with the DOC, they confirmed that registered staff have received training related to the use of the above forms for assessment of pain and that they are expected to complete them.
- Registered staff did not comply with the home's policy and procedure related to assessment of resident pain.

C) Resident #640 was identified as having chronic pain and received regular analgesic medication to manage this pain.
- Resident #640 indicated during an interview that they continued to experience pain. According to the clinical records, the physician increased the resident's regularly scheduled analgesic medication in November 2013. The resident continued to complain of pain in December 2013 and January 2014. A review of the resident's health records indicated that the "Pain Assessment Tool" had not been completed related to the change in the resident's pain. Further review of the resident's health records indicate that no quarterly pain assessments had been completed. It was confirmed by registered staff that the required pain assessments for resident #640 had not been completed.

The licensee did not ensure that the home's policies, procedures and protocols were complied with in respect of the organized falls prevention and management program required under sections 8 to 16 of the Act and under section 48 of this Regulation.

According to the home's Fall Prevention and Management Program policy (CN-F-05-1), a Post Fall Evaluation was to be completed after each fall to determine changes in a resident's status.

A) A review of the clinical record for resident #004 indicated that the resident had sustained five falls over a four month period in 2013-2014. According to the home's fall policy, titled "Fall Prevention and Management Program" (CN-F-05-1), a Post Fall Evaluation was to be conducted on residents who fell to determine changes in status. A review of the resident's clinical record indicated that a post fall evaluation had not been completed following falls this resident had sustained on four of the occasions when the resident sustained a fall. An interview conducted with the ADOC confirmed that the post fall evaluations had not been completed for the four falls identified, as required by the home's fall policy.

B) A review of the clinical record for resident #753 revealed that the resident had sustained two falls in 2014. A review of the clinical record for resident #753 revealed that a Post Fall Evaluation had not been completed after one of the falls sustained by the resident. An interview conducted with the DOC confirmed that the Post Fall Evaluation had not been completed for one of the falls sustained by the resident as required by the home's Fall Prevention and Management Program policy.

The licensee did not ensure that the home's policy related to Meal Service and Delivery was complied with.

The policy related to Meal Service and Delivery provided by the Nutrition Manager indicated that tray service should not be provided at the same time as regular dining service in order to ensure adequate supervision was available. The policy also indicated that trays would be set up and labeled with resident's name, diet and room number.
- During observation of tray service provided to residents on two separate occasions during the review, it was noted that the trays for residents receiving tray service were provided to residents at the beginning of the meal service.
- During an interview with the Nutrition Manager, they confirmed that tray service is provided to residents who eat in their rooms at the beginning of the dining room meal service. The Nutrition Manager indicated that on the south wing there were three staff designated to serve and provide assistance to residents who eat

in their rooms. On the extension wing there were two staff designated to serve and assist residents who eat in their rooms.
- It was noted during the observation of meal service that trays did not have labels indicating the resident's name, diet or room number as per the policy. (214)

2. The licensee did not ensure that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented

A) Resident #640 was identified as having chronic pain and received regular analgesic medication to manage this pain. According to registered staff, residents identified as having pain were to be assessed on a weekly basis and the level of pain is documented in the Medication Administration Records (MAR). It was noted that in January 2014, the level of pain was not documented weekly four out of four times.
- During a review of the resident's clinical records, a partially completed Pain Assessment Tool was noted with no date and no signature documented. The level of pain was documented as zero however; it also indicated that the resident had "horrible" pain.
- It was confirmed by registered staff that the Pain Assessment Tool had not been completed and that the assessments documented had conflicting information.

B) On an identified date in 2013, resident #735 was complaining of pain described as a burning sensation. According to the clinical records, the registered nurse documented that staff on the next shift would be made aware and a sample of urine for culture and sensitivity would be collected as needed. There was no further documentation in the clinical records related to this occurrence of pain or the outcome of the urine sample.
- It was confirmed by registered staff that follow up documentation had not been completed.

C) A review of the plan of care for resident #004, including the progress notes and physician's orders, revealed that on an identified date in 2013, the attending physician was contacted and provided verbal authorization for a treatment to be provided to the resident.
- A review of the progress notes over the identified time frame revealed that there was no documentation that the POA (Power of Attorney) for resident #004

was notified and consented to the intervention.
- An interview with a member of the registered staff confirmed that documentation of consent for an intervention should have been recorded in the progress notes of a resident's health care record.
- The member of the registered staff verified that the POA for resident #004 was contacted and consent was obtained for the treatment however, this was not documented in the health care record of resident #004.

D) During a review of the progress notes for resident # 646, it was noted that there were a number of concerns identified but no follow up documentation was found related to these concerns.
- On an identified date in 2014, the progress note indicated that that staff had noted that the resident had symptoms of a urinary tract infection and that it was noted in the calendar to obtain a urine specimen. There was no further follow up documentation in the progress notes related to whether the specimen was obtained or not or what the results were of the urine culture.
- On an identified date in 2014, the progress note indicated that the resident's had excoriation of the skin on an identified part of their body and that a treatment cream was applied. There was no further follow up documentation related to this issue.
- On an identified date in 2014, the progress note indicated that an area of the resident's body was very red but staff were unable to check at that time as the resident was in their wheelchair. There was no further follow up related to this concern in the resident's progress notes. (508)

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

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 : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare and submit a plan that addresses the following:
1. When all bed systems will be re-assessed and by whom to determine if they pass zones of entrapment 1-4.
2. What immediate actions will be taken with respect to resident safety where one or more entrapment zones has failed on a bed system.
3. By whom and how will all residents be assessed to determine if their bed system (mattress, rails, mechanical vs electric bed frame) is appropriate for their individual needs.
The plan shall be implemented within 6 months of the date of this Order.
The written plan shall be submitted to Bernadette Susnik by May 30, 2014 by email to Bernadette.Susnik@ontario.ca or by mail to Bernadette Susnik, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care Improvement and Compliance Branch, 119 King St. W., 11th floor, Hamilton, ON L8P 4Y7.

Grounds / Motifs :

1. The licensee did not ensure that when bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #661 was observed to be using one partial bed rail at the top of their bed.
- An assessment of the bed system related to entrapment risk completed in 2013 confirmed that the bed system failed the entrapment risk in one or more zones. The bed had not since been retested.
- Staff interviewed confirmed that the resident used one bed rail in bed to assist them with mobility.
- The plan of care for the resident indicated that the resident used one side rail in bed for positioning. Personal Assistive Safety Device (PASD).
- The home's policy and procedure related to use of PASD indicated that the Restraint/PASD Assessment which included evaluation of risk factors, alternatives considered and trialed was to be completed upon admission, quarterly and with a change in condition that impacted the use of the restraint/PASD.
- It was noted that in the care plan section of the resident's chart there was one "Restraint/PASD Assessment ", but it was not complete. The form did not indicate the type of PASD/Restraint being assessed and there were no dates found on the form or signatures for persons completing the form. The form was not completed to include the identified areas related to whether the resident had the potential to try to climb over the rails, medications that might impact safety, side rail alternatives that had been tried, whether the side rails created more risk, fluctuations in cognitive status and many others that may be relevant to the assessment of a resident for entrapment risk.

B) On observation, resident #004's bed system was noted to have a therapeutic surface with two half rails in the upright position. It was noted that the resident's bed failed entrapment risk for more than one zone. There was no nursing assessment completed for bed entrapment in relation to the use of the therapeutic surface and two half rails. An interview conducted with the ADOC confirmed that no assessment had been completed.

(167)

2. The licensee did not ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident bed systems in the home were evaluated for entrapment zones in 2013 by an external company. The results of the audit revealed that more than

80% of the beds failed one or more entrapment zones. The recommendation by the auditor was to replace aging mattresses, add mattress keepers, tighten rails and add bed rail end caps. Management staff for the home reported that some new mattresses were purchased, rail end caps added, rails tightened and mattress keepers added. However, since that time, beds have been re-arranged and relocated, mattress keepers have broken off or are still missing on some beds and rails have become loose. Using the audit results to locate the beds to verify compliance could not be completed, as the beds were no longer in rooms as originally identified. Mattresses that may have passed testing on a particular bed frame have since been moved onto other beds. Management staff did develop a method or system to ensure that bed frames and mattresses that passed entrapment zone testing remained together. During the inspection, numerous residents were identified to be sleeping in beds with both side rails in the raised position where the status of the entrapment compliance was unknown. Over 10 therapeutic surfaces were identified, which are of a design that makes them a high risk for entrapment due to their compressible nature. Residents were identified sleeping on these beds with one or both bed rails in the raised position in six identified resident rooms. No bolsters, gap fillers or rail pads were observed to be in place to reduce entrapment zones between the rail and mattress. No other alternatives were instituted with respect to rail use.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 08, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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. 2007, chap. 8

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 8th day of April, 2014

Signature of Inspector / Signature de l'inspecteur : Marilyn Tone

Name of Inspector / Nom de l'inspecteur : MARILYN TONE

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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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 05, 2014;	2014_201167_0010 (A1)	H-000298-14	Resident Quality Inspection

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5

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

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

BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Please see attached Order #005 with amended compliance date.

Issued on this 5 day of May 2014 (A1)

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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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 05, 2014;	2014_201167_0010 (A1)	H-000298-14	Resident Quality Inspection

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5

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

BERNADETTE SUSNIK (120) - (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 17, 18, 19, 20, 24, 25, 26, 27, 28, 31 and April 1, 2014.

The following inspections were completed simultaneously with this Resident Quality Inspection and will be included in this report:

Complaint Logs: #H-000732-13, H-000043-14, H-000113-14, H-000343-14, H-000255-14 and Critical Incident Logs # H-000225-14 and H-000037-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Food Service Manager, Assistant Director of Care (ADOC), Resident Assessment Instrument Coordinator (RAI Coordinator) Recreation Manager, Staffing Scheduler, Maintenance Manager, registered staff, personal support workers (PSWs), residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed resident care and meal service, reviewed the health files for identified residents, relevant policies and procedures, training record, employee files, family and residents' council minutes, other relevant reports and investigation notes completed by the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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:
2. Every resident has the right to be protected from abuse. 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:
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. [LTCHA s.3(1)2] was previously issued as a VPC in April 2013 and August 2013 and as a Compliance Order in December 3013.

The licensee did not ensure that resident's rights were fully respected and promoted when resident #002 was not protected from abuse

It was reported on an identified date in 2013, that a staff member verbally and physically abused resident #002. [s. 3. (1) 2.]

2. The licensee did not ensure that the right of residents at the home to be afforded privacy was fully respected and promoted.

Privacy curtains in resident rooms did not completely enclose the beds. A ceiling mounted lift track was installed in many rooms in 2013, dissecting many of the privacy curtain tracks. A gap of about 3-4 inches was apparent when curtains were tested. According to the maintenance manager, magnets were once attached to the curtains to keep the gap closed. However no magnets were found attached to curtains. [s. 3. (1) 8.]

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. 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. [LTCHA s.5] was issued as VPC in October 2012.

The licensee did not ensure that the home was a safe and secure environment for its residents during the inspection conducted in March 2014.
A) The shower room located in the 200 wing was not designed to allow water to

adequately drain away into the drain. After running the shower wand for 1 minute, a pool of water had accumulated and was beginning to climb up over the raised flooring where it would eventually spill out into the corridor. The pooling water was observed to be trickling very slowly into the drain. Staff were observed on several days using flannel blankets to create a dam or barrier around the shower area where residents are seated to keep it from spilling out into the hall. Management provided staff with a squeegee to push the water into the drain once showering had been completed. However during showering, staff and residents would be standing in a pool of water which is a safety concern for both residents and staff.

B) A table (large enough to accommodate 2 chairs) was left at the end of the corridor outside an of an identified resident room in March 2014. When personal support workers were questioned about the reason, they stated that visitors will often use it for snacks when visiting with residents. Staff identified that no portable over bed tables with wheels were available, however management staff identified that at least five were in storage. Objects such as tables in corridors cause obstructions for residents and are a safety hazard when having to evacuate during a fire or other emergency.

C) An unsafe raised toilet seat was identified on a toilet in a resident's room. The seat was very loose and did not have any tightening adjustments.

D) Electrical and television cable cords were identified sitting loosely on the floor in many resident rooms. The cables were not secured around the perimeter of the room or tied off in any way to keep them from entangling around other objects. Staff and residents have the potential of tripping or getting caught on these cords when working around the bed area. Two identified rooms were of particular concern as a modem was found on the floor along with multiple cords in both rooms.

E) Badly damaged wardrobe surfaces were observed in two resident rooms. The surfaces were so rough and splintered that they could not be cleaned. The furniture appeared to belong to the residents which is required to be evaluated for condition on a regular basis as would home-owned furniture.

F) Over bed lights were being used as shelving, with vases, picture frames and other objects stored on top of them in identified rooms. The administrator reported that these objects have been removed in the past however family members, residents and possibly staff continue to replace the items back onto the lights despite warnings.

G) Ceiling lifts installed in multiple resident rooms were observed to have spreader

bars hanging down at shoulder level in such a manner that staff and residents trying to gain access to their closet or night table would be hit in the head. The spreader bars were not retracted to their highest position.

H) A very loose bed rail was observed on a resident's bed. The resident reported that staff apply the rail for the resident when they are in bed nightly.

I) It was observed on an identified date during this inspection, in the hallway of Wing 100 that a hacksaw was laying on the hand rail that is used by residents. Contractors were working in a resident's room on the unit and left the hacksaw. This was brought to the contractor's attention by the inspector immediately and the hacksaw was removed from the handrail.
It was observed the next day in the hallway of Unit 200 that a hacksaw was laying on a box outside resident's rooms in the hallway. Contractors were working in a resident's room on the unit. This was immediately brought to the attention of the Maintenance Co-ordinator and the Administrator who confirmed this was a hazard to the residents. [s. 5.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 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. The infection prevention and control program did not include measures to prevent the transmission of infections. Measures were not instituted to ensure that the

following were addressed:

Personal hygiene products are not being stored properly. Bar soap was noted in identified resident washrooms sitting on communal metal soap dishes. Numerous vanity tops were observed to have a metal soap dish mounted to the side of the vanity which were shared by four residents. Residents did not have their own soap dishes or containers in which to store the soap. Roll-on deodorants, combs and hair brushes without resident names were observed to be stored in all tub rooms. Infection control prevailing practice is to ensure that hygiene products are returned to the resident and stored in their own designated drawer, closet, container or bag after each use and not in a communal space. In shared resident washrooms, these products were also identified to be sitting out on vanity tops unlabeled instead of within resident's drawers. [s. 86. (2) (b)]

2. The home's policy CN-C-21-1 dated May 2011 stated that the tub is to be rinsed, surfaces cleaned with disinfectant (allow for contact time) and rinsed. The policy does not address the differences between the ARJO tubs and the pedestal tubs (ARJO tubs have a disinfectant dispensing system built into the units) and the policy is missing information about the type of disinfectant, how long to apply the disinfectant, and whether the tub is to receive a physical scrubbing.
A low level disinfectant called AIRX44 was identified in all tub rooms. ARJO tub cleaning instructions state that the disinfectant is to be scrubbed around the surface, allowed to sit for 10 minutes and then rinsed. ARJO disinfectants provide 800 p.p.m. of an active ingredient to kill organisms whereas the AIRX44 disinfectant is approximately 400 p.p.m. AIRX44 disinfectant is applied manually by hand via an aerosol spray bottle and is inconsistently applied as opposed to using the tub's dispensing system which is applied via a hand wand and the solution is dispensed in the form of a liquid stream.

Staff are not able to wash and disinfect personal care articles such as wash basins and bed or slipper pans when necessary. Wash basins are considered to be class 1 medical devices and can be semi-critical depending on how they are used. Basins can become heavily contaminated when used for incontinence cleanup, indwelling catheter care and emesis collection and if not cleaned properly become a vehicle in the spread of disease causing organisms. Staff reported that the basins were rinsed and sprayed with a disinfectant called AIRX44 and wiped out with paper towel in the resident's washroom after use. Signage was observed to be posted in some washrooms identifying this procedure. However, they are not able to submerge them for deep cleaning when necessary.

Large washbasins were observed hanging on walls in resident washrooms. Many were noted to be covered in dust over a 3 day period in identified washrooms from a lack of regular use and inappropriate storage methods. Soap scum was observed on basins in identified washrooms. The basins provided were too large to be properly submerged for deep cleaning in any of the home's available sinks. The home's policies and practices related to the current handling of soiled personal care articles does not address how they will be deep cleaned when necessary to remove residues that cannot be removed by daily spraying and wiping.

According to the home's policy CN-C-21-1, staff are required to wash and rinse the basin, but the policy does not state where this activity is to take place. There are no details about the type of disinfectant to use and how it is to be applied. The policy had not been updated but it also is missing a component related to deep cleaning when necessary of items in a sink, submerged.

Soiled utility rooms in each wing were observed to be structurally insufficient in size to accommodate the cleaning and disinfection process of personal care articles such as wash basins and bed pans. These rooms were equipped with a small hand sink and a hopper, neither of which can be used for cleaning purposes. A sign posted in the room above the hopper instructed staff to "rinse and use AirX44". A larger soiled utility room was identified at the 200/500 wing intersection which could support the installation of a large sink in which to deep clean and process basins and slipper pans. This option was discussed with the infection control designate. [s. 86. (2) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must 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. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

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

Findings/Faits saillants :

1. The licensee did not ensure that the home's policies, procedures and protocols were complied with in respect to the organized pain program required under sections 8 to 16 of the Act and under section 48 of this Regulation.

The home's policy related to Pain Management and a memorandum provided to staff by the DOC in December 2013 directs registered staff to use the "PACSLAC" form to assess pain for the cognitively impaired residents and the "Pain Assessment Tool for the Cognizant" for the residents who are not cognitively impaired.
The policy and the memorandum directed staff to complete these assessments on admission, re-admission, when changes occur and quarterly.

A) A review of the clinical record for resident #705 indicated that they experienced moderate pain on a daily basis and received routine analgesics. According to the Resident Assessment Instrument Minimum Data Set completed for the resident in 2014, under RAP Pain, resident #705 had changes made to the amount of analgesic medication to be received by the resident three times during the previous two months. Interviews conducted with registered staff, confirmed that no Pain Assessment Tool had been completed for this resident quarterly or with any changes, as required by the home's pain policy and memorandum from the DOC.

B) During a review of the health file for resident #661, it was noted that the resident was taking analgesic medication to control their pain on a regular schedule and also took some breakthrough medication for pain. It was also noted that no quarterly pain assessments completed for the resident could be found. Registered staff interviewed confirmed that no pain assessments were completed for the resident.
- During interviews with a registered staff they indicated that these assessments were to be completed by the RAI Co-ordinator.
- During an interview with the RAI Co-ordinator, they confirmed that they were not expected to complete these pain assessments and are only responsible for the quality portion of documentation related to pain.
- During an interview with the DOC they confirmed that registered staff have received training related to the use of the above forms for assessment of pain and that they were expected to complete them.
- Registered staff did not comply with the home's policy and procedure related to assessment of resident pain. (167)

C) Resident #640 was identified as having chronic pain and received regular analgesic medication to manage this pain.
- Resident #640 indicated during an interview that they continued to experience pain. According to the clinical records, the physician increased the residents regularly scheduled analgesic medication in 2013. The resident continued to complain of pain over the next two months. A review of the resident's health records indicate that the "Pain Assessment Tool" had not been completed related to the change in the residents pain. Further review of the resident's health records indicate that no quarterly pain assessments had been completed. It was confirmed by registered staff that the required pain assessments for resident #640 have not been completed. [s. 30.]

2. The licensee did not ensure that the home's policies, procedures and protocols were complied with in respect of the organized falls prevention and management

program required under sections 8 to 16 of the Act and under section 48 of this Regulation.

The home's "Fall Prevention and Management Program policy" (CN-F-05-1)indicated that a Post Fall Evaluation was to be completed after each fall to determine changes in a resident's status.

A) A review of the clinical record for resident #004 indicated that the resident had sustained five falls over a four month period in 2013-2014. A review of the resident's clinical record indicated that a post fall evaluation had not been completed following four of the identified falls. An interview conducted with the ADOC confirmed that the post fall evaluations had not been completed for the four falls identified, as required by the home's fall policy.

B) A review of the clinical record for resident #753 revealed that the resident had sustained two falls in 2014. A review of the clinical record for resident #753 revealed that a Post Fall Evaluation had not been completed after the first fall that the resident sustained in 2014. An interview conducted with the DOC confirmed that the Post Fall Evaluation had not been completed for the identified fall. as required by the home's Fall Prevention and Management Program policy. [s. 30.]

3. The licensee did not ensure that the home's policy related to Meal Service and Delivery was complied with.

- The policy related to Meal Service and Delivery provided by the Nutrition Manager indicated that tray service should not be provided at the same time as regular dining service in order to ensure adequate supervision was available. The policy also indicated that trays would be set up and labelled with resident's name, diet and room number.
- During observation of tray service provided to residents on two separate occasions during the review, it was noted that the trays for residents receiving tray service were provided to residents at the beginning of the meal service.
- During an interview with the Nutrition Manager, they confirmed that tray service is provided to residents who eat in their rooms at the beginning of the dining room meal service. The Nutrition Manager indicated that on the south wing there were three staff designated to serve and provide assistance to residents who eat in their rooms. On the extension wing there were two staff designated to serve and assist residents who eat in their rooms.
- It was noted during the observation of meal service that trays did not have labels

indicating the resident's name, diet or room number as per the policy. [s. 30. (1)]

4. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.[s.30(2)]

During a review of the progress notes for resident # 646 it was noted that there were a number of concerns identified but no follow up documentation was found related to these concerns.
- On an identified date in 2013, the progress note indicated that that staff had noted that the resident had symptoms of a urinary tract infection and that it was noted in the calendar to obtain a urine specimen. There was no further follow up documentation in the progress notes related to whether the specimen was obtained or not or what the results were of the urine culture.
- On an identified date in 2014, the progress note indicated that the resident's had skin excoriation to an identified area and that a treatment was applied. There was no further follow up documentation related to this issue.
- On another identified date in 2014, the progress note indicated that an area of the resident's body was very red but staff were unable to check at that time as the resident was in their wheelchair. There was no further follow up related to this concern in the resident's progress notes. [s. 30. (2)]

5. A review of the plan of care for resident #004 on an identified date in 2014, including the progress notes and physician's orders, revealed that on an identified date in 2013 the attending physician was contacted and provided verbal authorization for a treatment to be provided to #004.
- A review of the progress notes for the resident revealed that there was no documentation to indicate that the Power of Attorney (POA) for resident #004 was notified and consented to the intervention.
- An interview with a member of the registered staff confirmed that documentation of consent for an intervention should have been recorded in the progress notes of a resident's health care record.
- The member of the registered staff verified that the POA for resident #004 was contacted and consent was obtained for the treatment, however, this was not documented in the health care record of resident #004. [s. 30. (2)]

6. An interview with resident #004's family in 2014, indicated that approximately one month prior, an incident had occurred in which the resident sustained an injury. A review of this resident's clinical records over the identified time frame did not identify

any documentation in the clinical record of this incident having occurred. An interview conducted with the ADOC indicated that the home was informed by the family of the same incident and that no documentation in regards to the reporting of this incident had occurred. [s. 30. (2)]

7. Resident #640 was identified as having chronic pain and receives regular analgesic medication to manage this pain. According to registered staff, residents identified as having pain are assessed on a weekly basis and the level of pain is documented in the Medication Administration Records (MAR). It was noted in an identified month in 2014, the level of pain was not documented weekly as required four out of four times.
- During a review of the resident's clinical records, a partially completed Pain Assessment Tool was noted with no date and no signature documented. The level of pain was documented as zero however; it also indicated that the resident had "horrible" pain.
- It was confirmed by registered staff that the Pain Assessment Tool had not been completed and that the assessments documented had conflicting information.

B) On an identified date in 2013 resident #735 was complaining of pain described as a burning sensation. According to the clinical records, the registered nurse documented that staff on the next shift would be made aware and a sample of urine for culture and sensitivity would be collected as needed. There was no further documentation in the clinical records related to this occurrence of pain or the outcome of the urine sample. It was confirmed by registered staff that follow up documentation had not been completed. [s. 30. (2)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that when bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #661 was observed to be using one partial bed rail at the top of their bed.
- An assessment of the bed system related to entrapment risk completed in 2013 confirmed that the bed system failed the entrapment risk in one or more zones. The bed has not since been retested.
- Staff interviewed confirmed that the resident used one bed rail in bed to assist them with mobility.
- The plan of care for the resident indicated that the resident used one side rail in bed for positioning. Personal Assistive Safety Device (PASD).
- The home's policy and procedure related to use of PASD indicated that the Restraint/PASD Assessment which included evaluation of risk factors, alternatives considered and trialed was to be completed upon admission, quarterly and with a change in condition that impacted the use of the restraint/PASD.
- It was noted that in the care plan section of the resident's chart there was one "Restraint/PASD Assessment ", but it was not complete. The form did not indicate the type of PASD/Restraint being assessed and there were no dates found on the form or signatures for persons completing the form. The form was not completed to include areas related to whether the resident had the potential to try to climb over the rails, medications that might impact safety, side rail alternatives that had been tried, whether the side rails created more risk, fluctuations in cognitive status and many others that may be relevant to the assessment for entrapment risk.

B) On observation, resident #004's bed system was noted to have a special surface with two half rails in the upright position. It was noted that the resident's bed failed entrapment risk for more than one zone. There was no nursing assessment completed for bed entrapment in relation to the use of the air powered surface and two half rails. An interview conducted with the ADOC confirmed that no assessment had been completed (214). [s. 15. (1) (a)]

2. The licensee did not ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident bed systems in the home were evaluated for entrapment zones in 2013 by an external company. The results of the audit revealed that more than 80% of the beds failed one or more entrapment zones. The recommendation by the auditor was to replace aging mattresses, add mattress keepers, tighten rails and add bed rail end caps. Management staff for the home reported that some new mattresses were purchased, rail end caps added, rails tightened and mattress keepers added. However, since that time, beds have been re-arranged and relocated, mattress keepers have broken off or are still missing on some beds and rails have become loose. Using the audit results to locate the beds to verify compliance could not be completed, as the beds were no longer in rooms as originally identified. Mattresses that may have passed testing on a particular bed frame have since been moved onto other beds. Management staff did develop a method or system to ensure that bed frames and mattresses that passed entrapment zone testing remained together. During the inspection, numerous residents were identified to be sleeping in beds with both side rails in the raised position where the status of the entrapment compliance was unknown. Over 10 therapeutic surfaces were identified, which are of a design that makes them a high risk for entrapment due to their compressible nature. Residents were identified sleeping on these beds with one or both bed rails in the raised position in identified resident rooms. No bolsters, gap fillers or rail pads were observed to be in place to reduce entrapment zones between the rail and mattress. No other alternatives were instituted with respect to rail use. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 005

WN #6: The Licensee has failed to comply with LTCHA, 2007, 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).

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

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

Findings/Faits saillants :

1. The licensee did not ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #004's plan of care for falls/balance identified that floor mats were to be placed beside the resident's bed and that the bed was to be placed in the lowest position. The resident's bed system was observed on on an identified date during the inspection, with the presence of the ADOC and it was noted that only one fall mat was placed beside the resident's bed and that the bed was not placed in the lowest position. The ADOC confirmed that two fall mats were to be in place and that the bed was to be in the lowest position. [s. 6. (7)]

2. The licensee did not ensure that staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

The RAI Co-ordinator confirmed that the current practice in the home regarding resident's care plans was that they are updated electronically when changes occur and remain in the computer software system. Staff who provide direct care to a resident have access to the resident's kardex by the printed version placed in a binder at the nursing station and that the printed kardex is updated manually when changes occur.

A) A review of resident #004's printed kardex for falls/balance, did not identify fall interventions of a bed alarm in place; the residents bed to be in the lowest position and fall mats to be in place at the residents bedside and directed staff to see the care plan. An interview conducted with the ADOC confirmed that front line staff do not have access to the electronic care plans [s. 6. (8)]

3. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) A review of resident #004's clinical record indicated that on an identified date in 2014, the resident sustained an injury following a fall. A review of their plan of care did not identify the injury, the expected outcomes or the interventions required to care for the resident with the injury. Registered staff confirmed the plan of care was not updated when the resident's care needs changed upon return from the hospital. [s. 6. (10) (b)]

4. The licensee did not ensure that the plan of care for resident #705 was reviewed and revised when the resident's care needs changed.

In 2013, resident #705 was noted to be unable to be seated at the tables in the dining room and was unable to use over bed table in the dining room as an eating surface.
- The home's staff did try a number of interventions to try to accommodate seating for the resident in the dining room.
- The resident was also noted to refuse to go to the dining room at times for meals.
- It was observed that the resident now consistently eats meals in their room and the resident confirmed this.
- The plan of care for resident #705 was not reviewed and revised to indicate that the

resident routinely eats their meals in their room. [s. 6. (10) (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 the ensure that a)the care set out in the resident's plan of care is provided to the resident as specified in the plan, b) staff and others who provide direct care to the resident are kept aware of the contents of the plan of care and have convenient access to it and c) the resident is reassessed and their plan of care reviewed and revised at least every six months and any other time when the resident's care needs change or care set out in the plan is no longer necessary or has not been effective., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee of the home did not ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

6 windows and 3 glass sliding patio doors were observed in March 2014 to be missing a restriction device to limit the opening of the window or door to a maximum of 15 cm. Windows in identified resident rooms and the large sliding glass patio doors located in the garden room, main lounge (100/200 wing area) and back lounge (500/600 wing area) were found unrestricted. The method of restricting the windows/doors has not been successful in each case, as standard screws were drilled into the metal frame of the window/door either at the bottom or both at the top and bottom. It appears that staff, residents or visitors have been able to remove these screws to allow the window/door to fully open. The management of the home had maintenance staff re-enforce the windows/doors with a different type of restriction device after being informed.[s. 16.]

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 window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The resident-staff communication and response system was not available in every area accessible by residents. Activation stations, which connect to the enunciator panel located at a nurse's station and alert staff that assistance is needed, were not equipped in 2 dining rooms or in the 3 available lounge spaces used by residents. [s. 17. (1) (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 the home is equipped with a resident-staff communication and response system that e) is available in every area accessible by residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee of the long-term care home did not ensure that the lighting requirements set out in the Table to this section were maintained.

A Sekonic Handi Lumi illumination light meter was used to measure various areas of the home such as resident bedrooms, bathrooms, common areas and corridors. Outdoor lighting conditions at the time of the inspection were overcast. The meter was held 0.8 meters above and parallel to the ground and held away from the body to avoid shadowing. Daylight affecting the meter could not be controlled for in all areas as window coverings were minimal or allowed for some seepage and therefore the readings may not be as accurate.

In corridors, measurements were taken between the ceiling flush mounted fluorescent light fixtures (luminaires) which were 2 feet by 2 feet in size as well as directly below them. The home consisted of 6 corridors, identified as wings 100 through to wings

600. In all 6 wings, the luminaires were spaced either 6, 8 or 10 feet apart, depending on the location of sprinkler heads and heat sensors. Lux levels below the luminaires were well above the required level of 215.28 lux, however the lux between two luminaires spaced 8 or 10 feet apart was between 50 and 125. The level of lux was not maintained at a consistent and continuous 215.28.

The lounge space located in the 500/600 area was equipped with 10 recessed pot lights (ceiling height approximately 10 feet) and 4 fluorescent ceiling mounted luminaires on a ceiling that was approximately 20 feet high. The natural day light could not be excluded as there were no window coverings. The lux directly under one pot light was 100. The lux under the fluorescent luminaires was 300. The lux level between the pot lights was 20. The lounge near the 100/200 wing was designed identically to the lounge in the 500/600 wing area and had the same types of luminaires and illumination levels. The minimum requirement is 215.28 lux.

The dining room located in the 500/600 wing area was equipped with 6 pot lights upon the entry section and the ceiling height was approximately 10 feet. The rest of the dining area had a higher ceiling with 5 fluorescent illuminaires. The natural day light could not be excluding during the measurements. The lux under the pot lights was 100 -175 (furthest point away from the windows). The corridor that wraps around the nurses' station in the 500/600 wing area was equipped with 8 pot lights with a lux of 100. The main nurse's station near the front entrance was also equipped with the same pot lights and illumination levels. The minimum requirement is 215.28 lux.

The resident rooms were equipped with several illuminaires, one at the entrance and two within the larger bedrooms. The illuminaires were ceiling mounted, round dome-type lights with opaque glass and they emitted a lux of 100. In an identified room, all window coverings were drawn and all lights, including the over bed lights were turned on and when standing centrally in the room, the general lux was 20-50. [s. 18.]

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 lighting requirements set out in the Table to this section are maintained, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred shall immediately report the suspicion and the information upon which it is based to the Director: 1. Misuse or misappropriation of a resident's money.

A) According to the clinical record for resident #705, on an identified date in 2013, the resident reported to staff that in the last two weeks, they had an identified amount of money missing. A review of the submitted Critical Incident Report indicated that this incident was not reported to the Director, until the following day. The DOC confirmed that the report was not submitted immediately, as required.
- According to the clinical record for resident #705, on another identified date in 2013, the resident reported to several staff that another identified amount of money was missing from their room. A review of the submitted Critical Incident Report indicated that this incident was not reported to the Director, until four days later. The DOC confirmed that the report was not submitted immediately, as required.
- According to the clinical record for resident #705, on a third identified date in 2013, the resident reported to staff that they were missing an identified amount of money. A review of the submitted Critical Incident Report indicated that this incident was not reported to the Director, until the following day. The Administrator confirmed that the report was not submitted immediately, as required. [s. 24. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that if there are reasonable grounds to suspect that the following has occurred or may occur the licensee shall immediately report the suspicion and the information upon which it is based to the Director: Misuse or misappropriation of a resident's money, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) According to the clinical record, resident #735 had ongoing complaints of pain and received routine and as needed (PRN)analgesic medication to manage their pain. Resident #735 received PRN analgesic medication nine times in November, 2013, 21 times in December, 2013, 12 times in January, six times in February, and five times in March, 2014.
- The plan of care for resident #735 indicated that an increase in their pain medication was ordered on in April 2013 and that staff were to monitor for effectiveness and inform the physician if the changes were ineffective.
- According to the resident's clinical records, and confirmed by registered staff, there has been no reassessment related to the ineffectiveness of the medication intervention. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose., to be implemented voluntarily.

WN #12: 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).

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. The licensee has not ensured that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, procedures were not developed or implemented to ensure that there is a process to report and locate residents' lost clothing and personal items.

On an identified date in 2014, the laundry room was toured and a rack of overloaded unclaimed clothing items was observed. Laundry staff could not confirm how long the items had been hanging on the rack and could not identify which items were donated and which items belonged to residents currently residing in the home. The home has not adequately designed a process to locate residents' lost clothing. The clothing hanging on the lost and found rack is difficult to search through and donated and lost items were not separated out. According to the activation manager, the lost clothing is put in a box and put out for families and residents 3 times per year. No written procedures for this process was available and no procedures were available that dealt with how long lost items are kept, when they are displayed, how they are separated form donated items, how donated items are managed.

Residents reported to inspectors that they had missing clothing items which were never returned. The residents confirmed that the items were labeled, that they complained to personal support workers, were not given a form to complete and never heard back about the course of action anyone took. The home's policy (without an identifying policy #) requires staff to complete a form with the details of the clothing item and a summary of what was done to try and locate the item. The blank forms were available to all staff in the soiled utility rooms on the bulletin boards. If the item cannot be located, the form is to be given to the administrator for further follow-up. This was not done for the three residents who complained about missing items. No monitoring of this program in general has been conducted to determine if staff are following the procedures. [s. 89. (1) (a) (iv)]

2. As part of the organized program of laundry services under clause 15 (1) (b) of the Act, the licensee of a long-term care home did not shall ensure that linen is maintained in a good state of repair. Linen includes pillows which were found to be poor condition with cracked exterior surfaces in identified resident rooms. [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 that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, procedures are developed or implemented to ensure that there is a process to report and locate residents' lost clothing and personal items and to ensure that linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odour, to be implemented voluntarily.

WN #13: 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee did not ensure that there is in place a hand hygiene program in accordance with prevailing practices with access to point-of-care hand hygiene agents.

Point-of-care hand hygiene agents, in accordance with prevailing practices, are required to be provided where care is provided, generally inside resident bedrooms. Hand hygiene agents were not made available in resident rooms in the 500 and 600 wings (an area for residents with cognitive impairments). The reason provided for not installing them in these rooms was the fear that residents would ingest the product. However, the product is encased in a bag inside of a holder which makes it very difficult to ingest adequate amounts to cause injury. [s. 229. (9)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none with with prevailing practices, and with access to point-of-care hand hygiene agents, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee did not report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

A) According to the clinical record, on an identified date in 2013, resident #705, informed staff they were missing an identified amount of money. The licensee submitted a Critical Incident to the Director. The agent of the Director requested the licensee to amend the Critical Incident upon completion of the home's investigation. A review of the home's submitted critical incidents as well as an interview conducted with the DOC, confirmed that the licensee did not conduct an investigation and did not submit the results of the investigation to the Director, as required.
- According to the clinical record, on another identified date in 2013, resident #705, informed staff they were missing an identified amount of money. The licensee submitted a Critical Incident to the Director. The agent of the Director requested the licensee to amend the Critical Incident, indicating the outcome of the in-home investigative process and to also provide alternate options and/or interventions that have been discussed with the resident and/or Power of Attorney, to prevent recurrence. A review of the home's submitted critical incidents as well as an interview conducted with the DOC, confirmed that the licensee did not conduct an investigation and did not submit the results of the investigation to the Director, as required.
- According to the clinical record, on a third identified date in 2013, resident #705, informed staff that they were missing money. The licensee submitted a Critical Incident to the Director. The agent of the Director requested the licensee to amend the Critical Incident to include how the home had investigated regarding the missing money, other than contacting police and the long term plan to prevent re-occurrence. A review of the home's submitted critical incidents as well as an interview conducted with the DOC, confirmed that the licensee did not conduct an investigation and did not submit the results of the investigation to the Director, as required. [s. 23. (2)]

WN #15: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

An interview conducted during the inspection with the Council President, indicated that the meal and snack times had not been reviewed by the Residents' Council. A review of the residents' council minutes from January 2013 till present, and confirmed by the Director of Therapeutic Recreation Services, confirmed that the meal and snack times had not been reviewed by the Resident's Council. [s. 73. (1) 2.]

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results.

An interview conducted with the Family Council lead during this inspection, indicated that the Family Council was not sought out for their advice in developing and carrying out the Satisfaction Survey. The Administrator confirmed that the advice of the Resident's Council and the Family Council is not obtained in developing and carrying out the Satisfaction Survey as the survey is designed by the Corporation, forwarded to the home and that the home sends out the survey via mail. [s. 85. (3)]

WN #17: 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. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours. The tub room located in the 500 wing had strong lingering odours on two identified days during the inspection after being mopped several times. Visible urine could not be detected but is suspected of having seeped down under the baseboards, into the exposed heater or under the tub where the floor appeared soiled and was more difficult to clean with just a mop. [s. 87. (2) (d)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure that at least quarterly, there was a documented reassessment of the resident's drug regime.

During a review of the health file for resident #661, it was noted that there was no quarterly medication review completed for the last quarter on their health file.
- During an interview with a registered practical nurse, they confirmed that no three Month Medication Review (3MMR) was on the resident's health file and indicated that it was still awaiting completion by the physician.
- The most current (3MMR) was last signed by the physician in November 2013 and covered the period of time between November 1, 2013 until January 31, 2014.
- There was no current 3MMR completed for the time period between February 1, 2014 and April 30, 2014. [s. 134. (c)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 207. Transfer list

Specifically failed to comply with the following:

s. 207. (1) Every licensee of a long-term care home shall keep a transfer list consisting of,
(a) the names of the residents of the home who are requesting a transfer from preferred accommodation in the home to basic accommodation in the home; O. Reg. 79/10, s. 207 (1).
(b) the names of the residents of the home who are requesting a transfer from private accommodation in the home to semi-private accommodation in the home; O. Reg. 79/10, s. 207 (1).
(c) the names of the residents of the home who are requesting a transfer from basic accommodation in the home to semi-private accommodation in the home; O. Reg. 79/10, s. 207 (1).
(d) the names of the residents of the home who are requesting a transfer from basic accommodation in the home to private accommodation in the home; O. Reg. 79/10, s. 207 (1).
(e) the names of the residents of the home who are requesting a transfer from semi-private accommodation in the home to private accommodation in the home; O. Reg. 79/10, s. 207 (1).
(f) the names of residents of the home who are requesting a transfer from a bed that is closing within 16 weeks to another bed in the home; and O. Reg. 79/10, s. 207 (1).
(g) where the home has a unit or area within the home that is primarily engaged in serving the interests of persons of a particular religion, ethnic origin or linguistic origin, the names of residents,
(i) who are requesting a transfer to the unit or area or out of the unit or area and based on the class of accommodation requested, and
(ii) who are in the unit or area and are requesting a change in class of accommodation within that unit or area. O. Reg. 79/10, s. 207 (1).

s. 207. (2) The licensee shall place the name of a resident on the transfer list referred to in subsection (1) when the request for a transfer is received. O. Reg. 79/10, s. 207 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home kept a transfer list consisting of the names of the residents of the home who had requested a transfer from basic accommodation in the home to private accommodation in the home.

An interview conducted with resident #705 indicated that in 2013, the resident requested a transfer from their basic accommodation in the home to a private accommodation in the home. A review of this resident's clinical record also indicated that in 2014, the resident continued to express their dissatisfaction with their accommodations and requested to be on a list for a private room. An interview conducted with the ADOC confirmed that the resident had made this initial request in 2013 and that the home did not add these request's to their transfer list as the home had not implemented a transfer list of resident requesting transfers. [s. 207. (1) (d)]

2. The licensee did not ensure that the name of a resident was placed on the transfer list when the request for a transfer was received.

An interview conducted with resident #705 indicated, that in 2013, the resident requested a transfer from their basic accommodation in the home to private accommodation in the home. A review of this resident's clinical record also indicated that in 2014, the resident continued to express their dissatisfaction with their accommodations and requested to be on a list for a private room. An interview conducted with the ADOC confirmed that the resident had made this initial request in 2013 and that home did not add this request or any subsequent requests to the transfer list at the time the requests were received and as a result, two private accommodations had become available in the home from during the time period that were not offered to this resident. [s. 207. (2)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home. O. Reg. 79/10, s. 305 (3).
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents. O. Reg. 79/10, s. 305 (3).

Findings/Faits saillants :

1. The licensee commenced minor alterations to the home without first receiving the approval of the Director.

During the inspection in March 2014, inspectors observed contractors working in resident rooms installing additional electrical outlets above their beds. In order to complete the task, the workers moved residents beds away from the wall while residents were still lying in their beds. The work created some dust and noise. 22 of the rooms were slated to have this work completed over the course of 3-4 days. According to the home's operational plan, provided after the work had already started, residents were to be out of their rooms when work was being completed in their rooms. A worker reported to an inspector that they did not have experience working inside of a long term care home where seniors have cognitive impairment. The home's plan summarizes that the contractors would report to the safety-coordinator and administrator for safety orientation and review of thelicensee's general safety guidelines and policy. This was not completed according to management of the home. [s. 305. (3)]

Issued on this 5 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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : BERNADETTE SUSNIK (120) - (A1)

Inspection No. / No de l'inspection : 2014_201167_0010 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-000298-14 (A1)

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

Report Date(s) / Date(s) du Rapport : May 05, 2014;(A1)

Licensee / Titulaire de permis : MARYBAN HOLDINGS LTD
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

LTC Home / Foyer de SLD : OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : LeAnne Ryan

To MARYBAN HOLDINGS LTD, 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)

Linked to Existing Order / Lien vers ordre existant: 2013_201167_0038, CO #001;

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

i. the Residents' Council,

ii. the Family Council,

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

iv. staff members,

v. government officials,

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

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that all residents at the home are protected from abuse.

Ontario

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.

Grounds / Motifs :

1. The licensee did not ensure that resident's rights were fully respected and promoted when resident #002 was not protected from abuse.

It was reported in 2013, that on an identified date in 2013, a staff member verbally and physically abused resident #002. The incident was observed and reported by a co-resident. (508)

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

Apr 22, 2014

Order # /
Ordre no : 002

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:

1. Ensure that all bed rails are tight-fitting and in good repair. Develop a preventive maintenance program that includes bed side rails as part of a routine check along with other bed components. The inspections are to be documented.
2. Ensure that all contractors are oriented to the licensee's general safety policies regarding resident safety before starting work in the long term care home.
3. Ensure that the shower located in the 200 wing drains adequately without staff intervention.
4. Secure all cording in resident rooms so that it does not pose a tripping hazard for staff and residents.
5. Ensure that all resident-owned furniture is assessed prior to admittance to the home and that it is assessed regularly thereafter for condition. Furniture in identified resident rooms that is in poor condition is to be removed or the resident is to have it repaired/resurfaced.
6. Objects are to be removed from all over bed lights and a routine monitoring program is to be developed to ensure lights remain free of objects.
7. All ceiling lift spreader bars are to be retracted to their highest position (just under the charger which is attached to the track) so that they do not pose an injury potential for staff and residents.

Grounds / Motifs :

1. The licensee did not ensure that the home was a safe and secure environment for its residents during the inspection conducted in March 2014.

A) The shower room located in the 200 wing was not designed to allow water to adequately drain away into the drain. After running the shower wand for 1 minute, a pool of water had accumulated and was beginning to climb up over the raised flooring where it would eventually spill out into the corridor. The pooling water was observed to be trickling very slowly into the drain. Staff were observed on several days using flannel blankets to create a dam or barrier around the shower area where residents are seated to keep it from spilling out into the hall. Management provided staff with a squeegee to push the water into the drain once showering had been completed. However during showering, staff and residents would be standing in a pool of water which is a safety concern for both residents and staff.

B) A table (large enough to accommodate 2 chairs) was left at the end of the corridor outside of an identified room during this inspection conducted in March 2014. When personal support workers were questioned about the reason, they stated that visitors will often use it for snacks when visiting with residents. Staff identified that no portable over bed tables with wheels were available, however management staff identified that at least five were in storage. Objects such as tables in corridors cause obstructions for residents and are a safety hazard when having to evacuate during a fire or other emergency.

C) An unsafe raised toilet seat was identified on a toilet in an identified resident room. The seat was very loose and did not have any tightening adjustments.

D) Electrical and television cable cords were identified sitting loosely on the floor in many resident rooms. The cables were not secured around the perimeter of the room or tied off in any way to keep them from entangling around other objects. Staff and residents have the potential of tripping or getting caught on these cords when working around the bed area. Two identified resident rooms were of particular concern as a modem was found on the floor along with multiple cords in both rooms.

E) Badly damaged wardrobe surfaces were observed in two identified resident rooms. The surfaces were so rough and splintered that they could not be cleaned. The furniture appeared to belong to the residents which is required to be evaluated for condition on a regular basis as would home-owned furniture.

F) Over bed lights were being used as shelving, with vases, picture frames and other objects stored on top of them in six identified resident rooms. The administrator reported that these objects have been removed in the past however family members, residents and possibly staff continue to replace the items back onto the lights despite warnings.

G) Ceiling lifts installed in multiple resident rooms were observed to have spreader bars hanging down at shoulder level in such a manner that staff and residents trying to gain access to their closet or night table would be hit in the head. The spreader bars were not retracted to their highest position.

H) A very loose bed rail was observed on a resident's bed in an identified resident room. The resident reported that staff apply the rail for the resident when they are in

bed nightly.

I) It was observed in the hallway of Wing 100 that a hacksaw was laying on the hand rail that is used by residents. Contractors were working in a resident's room on the unit and left the hacksaw. This was brought to the contractor's attention by the inspector immediately and the hacksaw was removed from the handrail.
It was observed the following day, in the hallway of Unit 200 that a hacksaw was laying on a box outside resident's rooms in the hallway. Contractors were working in a resident's room on the unit. This was immediately brought to the attention of the Maintenance Co-ordinator and the Administrator who confirmed this was a hazard to the residents.

(120)

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

Aug 12, 2014

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Order / Ordre :

The licensee shall ensure that:
1. All tubs with a built-in disinfection system be operational and equipped with the manufacturer's disinfection product.
2. All pedestal tubs which do not have a built-in disinfection system, be provided with an automatic dispensing system that will dispense the appropriate amount of disinfectant and water through a hand held shower wand.
3. Cleaning procedures be developed or obtained from the dispensing system manufacturer for the tubs and posted for staff referral in all tub rooms. A written policy and procedure for tub cleaning and disinfection using the automatic dispensing systems shall be updated and available to all staff.
4. The soiled utility room located at the intersection of wing 200 and 500 be equipped with a deep sink large enough to accommodate and submerge the largest personal care device for the purposes of cleaning and disinfection. The hopper may be removed to accommodate the sink. An automatic disinfection dispensing system shall be installed next to the sink.
5. The policy and procedure regarding the cleaning and disinfection of personal care devices shall be updated to include the use of the room and associated sink and disinfection dispensing system.

Grounds / Motifs :

1. The home's policy CN-C-21-1 dated May 2011 states that the tub is to be rinsed, surfaces cleaned with disinfectant (allow for contact time) and rinsed. The policy does not address the differences between the ARJO tubs and the pedestal tubs (ARJO tubs have a disinfectant dispensing system built into the units) and the policy is missing information about the type of disinfectant, how to apply the disinfectant, how long to apply the disinfectant, whether a brush is to be used and whether the tub is to receive a physical scrubbing. A low level disinfectant called AIRX44 was identified in all tub rooms. ARJO tub cleaning instructions state that the disinfectant is to be scrubbed around the surface, allowed to sit for 10 minutes and then rinsed. ARJO disinfectants provide 800 p.p.m of an active ingredient to kill organisms whereas the AIRX44 disinfectant is approximately 400 p.p.m. AIRX44 disinfectant is applied manually by hand via an aerosol spray bottle and is inconsistently applied as opposed to using the tub's dispensing system which is applied via a hand wand and

the solution is dispensed in the form of a liquid stream.

Staff are not able to wash and disinfect personal care articles such as wash basins and bed or slipper pans when necessary. Wash basins are considered to be class 1 medical devices and can be semi-critical depending on how they are used. Basins can become heavily contaminated when used for incontinence cleanup, indwelling catheter care and emesis collection and if not cleaned properly become a vehicle in the spread of disease causing organisms. Staff reported that the basins were rinsed and sprayed with a disinfectant called AIRX44 and wiped out with paper towel in the resident's washroom after use. Signage was observed to be posted in some washrooms identifying this procedure. However, they are not able to submerge them for deep cleaning when necessary.

Large washbasins were observed hanging on walls in resident washrooms. Many were noted to be covered in dust over a 3 day period in identified resident washrooms from a lack of regular use and inappropriate storage methods. Soap scum was observed on basins in identified resident washrooms. The basins provided were too large to be properly submerged for deep cleaning in any of the home's available sinks. The home's policies and practices related to the current handling of soiled personal care articles does not address how they will be deep cleaned when necessary to remove residues that cannot be removed by daily spraying and wiping.

According to the home's policy CN-C-21-1, staff are required to wash and rinse the basin, but the policy does not state where this activity is to take place. There are no details about the type of disinfectant to use and how it is to be applied. The policy had not been updated but it also is missing a component related to deep cleaning when necessary of items in a sink, submerged.

Soiled utility rooms in each wing were observed to be structurally insufficient in size to accommodate the cleaning and disinfection process of personal care articles such as wash basins and bed pans. These rooms were equipped with a small hand sink and a hopper, neither of which can be used for cleaning purposes. A sign posted in the room above the hopper instructed staff to "rinse and use AirX44". A larger soiled utility room was identified at the 200/500 wing intersection which could support the installation of a large sink in which to deep clean and process basins and slipper pans. This option was discussed with the infection control designate.

The infection prevention and control program did not include measures to prevent the

transmission of infections. Measures were not instituted to ensure that the following were addressed:

Personal hygiene products are not being stored properly. Bar soap was noted in identified resident washrooms sitting on communal metal soap dishes. Numerous vanity tops were observed to have a metal soap dish mounted to the side of the vanity which were shared by four residents. Residents did not have their own soap dishes or containers in which to store the soap. Roll-on deodorants, combs and hair brushes without resident names were observed to be stored in all tub rooms. Infection control prevailing practice is to ensure that hygiene products are returned to the resident and stored in their own designated drawer, closet, container or bag after each use and not in a communal space. In shared resident washrooms, these products were also identified to be sitting out on vanity tops, without labels. (120)

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

Aug 30, 2014

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. General requirements

Order / Ordre :

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.

1) The licensee shall prepare, implement and submit a plan to ensure that the home's policies, procedures and protocols with respect to the Falls Management and Pain Management and the policy related to the provision of Meal Service and Delivery at the home are complied with.
2) The plan shall also include identification of how the licensee will ensure that any actions taken with respect to a program including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The plan shall be submitted electronically to: Marilyn.Tone@ontario.ca by April 30, 2014

Grounds / Motifs :

1. The licensee did not ensure that the home's policies, procedures and protocols were complied with in respect to the organized pain program required under sections 8 to 16 of the Act and under section 48 of this Regulation.

The home's policy related to Pain Management and a memorandum provided to staff by the DOC in December 2013 directed registered staff to use the "PACSLAC" form to assess pain for the cognitively impaired residents and the "Pain Assessment Tool for the Cognizant" for the residents who are not cognitively impaired.
The policy and the memorandum directed staff to complete these assessments on admission, re-admission, when changes occur and quarterly.

A) A review of the clinical record for resident #705 indicated that they experienced moderate pain on a daily basis and received routine analgesic medication. According to the Resident Assessment Instrument Minimum Data Set, completed in March 2014, under RAP Pain, resident #705 had changes made to the amount of analgesic medication ordered for them three times during the previous quarter. Interviews conducted with registered staff, confirmed that no Pain Assessment Tool had been completed for this resident quarterly or with any changes, as required by the home's pain policy and memorandum from the DOC.

B) During a review of the health file for resident #661, it was noted that the resident received analgesic medication to control their pain on a regular schedule and also took some breakthrough medication when required for pain. It was also noted that no quarterly pain assessments completed for the resident could be found. Registered

staff interviewed confirmed that no pain assessments were completed for the resident.
- During interviews with registered staff, they indicated that these assessments were to be completed by the RAI Co-ordinator.
- During an interview with the RAI Co-ordinator, they confirmed that they are not expected to complete these pain assessments and are only responsible for the quality portion of documentation related to pain.
- During an interview with the DOC, they confirmed that registered staff have received training related to the use of the above forms for assessment of pain and that they are expected to complete them.
- Registered staff did not comply with the home's policy and procedure related to assessment of resident pain.

C) Resident #640 was identified as having chronic pain and received regular analgesic medication to manage this pain.
- Resident #640 indicated during an interview that they continued to experience pain. According to the clinical records, the physician increased the resident's regularly scheduled analgesic medication in November 2013. The resident continued to complain of pain in December 2013 and January 2014. A review of the resident's health records indicated that the "Pain Assessment Tool" had not been completed related to the change in the resident's pain. Further review of the resident's health records indicate that no quarterly pain assessments had been completed. It was confirmed by registered staff that the required pain assessments for resident #640 had not been completed.

The licensee did not ensure that the home's policies, procedures and protocols were complied with in respect of the organized falls prevention and management program required under sections 8 to 16 of the Act and under section 48 of this Regulation.

According to the home's Fall Prevention and Management Program policy (CN-F-05 -1), a Post Fall Evaluation was to be completed after each fall to determine changes in a resident's status.

A) A review of the clinical record for resident #004 indicated that the resident had sustained five falls over a four month period in 2013-2014. According to the home's fall policy, titled "Fall Prevention and Management Program" (CN-F-05-1), a Post Fall Evaluation was to be conducted on residents who fell to determine changes in status. A review of the resident's clinical record indicated that a post fall evaluation

had not been completed following falls this resident had sustained on four of the occasions when the resident sustained a fall. An interview conducted with the ADOC confirmed that the post fall evaluations had not been completed for the four falls identified, as required by the home's fall policy.

B) A review of the clinical record for resident #753 revealed that the resident had sustained two falls in 2014. A review of the clinical record for resident #753 revealed that a Post Fall Evaluation had not been completed after one of the falls sustained by the resident. An interview conducted with the DOC confirmed that the Post Fall Evaluation had not been completed for one of the falls sustained by the resident as required by the home's Fall Prevention and Management Program policy.

The licensee did not ensure that the home's policy related to Meal Service and Delivery was complied with.

The policy related to Meal Service and Delivery provided by the Nutrition Manager indicated that tray service should not be provided at the same time as regular dining service in order to ensure adequate supervision was available. The policy also indicated that trays would be set up and labeled with resident's name, diet and room number.
- During observation of tray service provided to residents on two separate occasions during the review, it was noted that the trays for residents receiving tray service were provided to residents at the beginning of the meal service.
- During an interview with the Nutrition Manager, they confirmed that tray service is provided to residents who eat in their rooms at the beginning of the dining room meal service. The Nutrition Manager indicated that on the south wing there were three staff designated to serve and provide assistance to residents who eat in their rooms. On the extension wing there were two staff designated to serve and assist residents who eat in their rooms.
- It was noted during the observation of meal service that trays did not have labels indicating the resident's name, diet or room number as per the policy. (214)

2. The licensee did not ensure that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented

A) Resident #640 was identified as having chronic pain and received regular analgesic medication to manage this pain. According to registered staff, residents identified as having pain were to be assessed on a weekly basis and the level of pain is documented in the Medication Administration Records (MAR). It was noted that in January 2014, the level of pain was not documented weekly four out of four times.
- During a review of the resident's clinical records, a partially completed Pain Assessment Tool was noted with no date and no signature documented. The level of pain was documented as zero however; it also indicated that the resident had "horrible" pain.
- It was confirmed by registered staff that the Pain Assessment Tool had not been completed and that the assessments documented had conflicting information.

B) On an identified date in 2013, resident #735 was complaining of pain described as a burning sensation. According to the clinical records, the registered nurse documented that staff on the next shift would be made aware and a sample of urine for culture and sensitivity would be collected as needed. There was no further documentation in the clinical records related to this occurrence of pain or the outcome of the urine sample.
- It was confirmed by registered staff that follow up documentation had not been completed.

C) A review of the plan of care for resident #004, including the progress notes and physician's orders, revealed that on an identified date in 2013, the attending physician was contacted and provided verbal authorization for a treatment to be provided to the resident.
- A review of the progress notes over the identified time frame revealed that there was no documentation that the POA (Power of Attorney) for resident #004 was notified and consented to the intervention.
- An interview with a member of the registered staff confirmed that documentation of consent for an intervention should have been recorded in the progress notes of a resident's health care record.
- The member of the registered staff verified that the POA for resident #004 was contacted and consent was obtained for the treatment however, this was not documented in the health care record of resident #004.

D) During a review of the progress notes for resident # 646, it was noted that there were a number of concerns identified but no follow up documentation was found related to these concerns.

- On an identified date in 2014, the progress note indicated that that staff had noted that the resident had symptoms of a urinary tract infection and that it was noted in the calendar to obtain a urine specimen. There was no further follow up documentation in the progress notes related to whether the specimen was obtained or not or what the results were of the urine culture.
- On an identified date in 2014, the progress note indicated that the resident's had excoriation of the skin on an identified part of their body and that a treatment cream was applied. There was no further follow up documentation related to this issue.
- On an identified date in 2014, the progress note indicated that an area of the resident's body was very red but staff were unable to check at that time as the resident was in their wheelchair. There was no further follow up related to this concern in the resident's progress notes. (508)

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

May 30, 2014

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall prepare and submit a plan that addresses the following:
1. When all bed systems will be re-assessed and by whom to determine if they pass zones of entrapment 1-4.
2. What immediate actions will be taken with respect to resident safety where one or more entrapment zones has failed on a bed system.
3. By whom and how will all residents be assessed to determine if their bed system (mattress, rails, mechanical vs electric bed frame) is appropriate for their individual needs.
The plan shall be implemented within 6 months of the date of this Order.
The written plan shall be submitted to Bernadette Susnik by May 30, 2014 by email to Bernadette.Susnik@ontario.ca or by mail to Bernadette Susnik, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care Improvement and Compliance Branch, 119 King St. W., 11th floor, Hamilton, ON L8P 4Y7.

Grounds / Motifs :

1. The licensee did not ensure that when bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #661 was observed to be using one partial bed rail at the top of their bed.
- An assessment of the bed system related to entrapment risk completed in 2013 confirmed that the bed system failed the entrapment risk in one or more zones. The

bed had not since been retested.
- Staff interviewed confirmed that the resident used one bed rail in bed to assist them with mobility.
- The plan of care for the resident indicated that the resident used one side rail in bed for positioning. Personal Assistive Safety Device (PASD).
- The home's policy and procedure related to use of PASD indicated that the Restraint/PASD Assessment which included evaluation of risk factors, alternatives considered and trialed was to be completed upon admission, quarterly and with a change in condition that impacted the use of the restraint/PASD.
- It was noted that in the care plan section of the resident's chart there was one "Restraint/PASD Assessment ", but it was not complete. The form did not indicate the type of PASD/Restraint being assessed and there were no dates found on the form or signatures for persons completing the form. The form was not completed to include the identified areas related to whether the resident had the potential to try to climb over the rails, medications that might impact safety, side rail alternatives that had been tried, whether the side rails created more risk, fluctuations in cognitive status and many others that may be relevant to the assessment of a resident for entrapment risk.

B) On observation, resident #004’s bed system was noted to have a therapeutic surface with two half rails in the upright position. It was noted that the resident’s bed failed entrapment risk for more than one zone. There was no nursing assessment completed for bed entrapment in relation to the use of the therapeutic surface and two half rails. An interview conducted with the ADOC confirmed that no assessment had been completed.

(167)

2. The licensee did not ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident bed systems in the home were evaluated for entrapment zones in 2013 by an external company. The results of the audit revealed that more than 80% of the beds failed one or more entrapment zones. The recommendation by the auditor was to replace aging mattresses, add mattress keepers, tighten rails and add bed rail end caps. Management staff for the home reported that some new mattresses were purchased, rail end caps added, rails tightened and mattress keepers added. However, since that time, beds have been re-arranged and relocated, mattress keepers have broken off or are still missing on some beds and rails have become loose. Using the audit results to locate the beds to verify compliance could not be completed, as the beds were no longer in rooms as originally identified. Mattresses that may have passed testing on a particular bed frame have since been moved onto other beds. Management staff did develop a method or system to ensure that bed frames and mattresses that passed entrapment zone testing remained together. During the inspection, numerous residents were identified to be sleeping in beds with both side rails in the raised position where the status of the entrapment compliance was unknown. Over 10 therapeutic surfaces were identified, which are of a design that makes them a high risk for entrapment due to their compressible nature. Residents were identified sleeping on these beds with one or both bed rails in the raised position in six identified resident rooms. No bolsters, gap fillers or rail pads were observed to be in place to reduce entrapment zones between the rail and mattress. No other alternatives were instituted with respect to rail use.
(120)

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

Oct 08, 2014(A1)

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.

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

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.

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
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

Order(s) of the Inspector

Ministère de la Santé et des Soins de longue durée

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 5 day of May 2014 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : BERNADETTE SUSNIK - (A1)

Service Area Office /
Bureau régional de services : Hamilton