Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 3, 2014	2014_271532_0010	L000319-14	Resident Quality Inspection

Licensee/Titulaire de permis

SAUGEEN VALLEY NURSING CENTER LTD
465 DUBLIN STREET, MOUNT FOREST, ON, N0G-2L3

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

SAUGEEN VALLEY NURSING CENTER
465 DUBLIN STREET, MOUNT FOREST, ON, N0G-2L3

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

NUZHAT UDDIN (532), DOROTHY GINTHER (568), SHARON PERRY (155), SHERRI GROULX (519)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 31, 2014 and April 1, 2, 3, 4, 7, 8, 9, 10, 11 and 14, 2014

Two concurrent CIS inspection were completed L-000128-14 and L-000378-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care, RAI-MDS Coordinator, Director of Food and Support Services, Director Recreation, Maintenance Manager , Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW), Dietary Aides, Head Chef, Housekeeping staff, Family and Resident Council Representatives, Family members and 40+ Residents.

During the course of the inspection, the inspector(s) toured all resident home areas and common areas, medication rooms, the kitchen, the servery, spa rooms, observed resident care provision, resident/staff interactions, dining services, medication administration, medication storage areas, reviewed relevant residents' clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection and observed general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

The following were noted during an observation:
- 3/3 (100%) of the residents were observed with one quarter rail and one half rail up.
- a resident was observed with two side rails.
- a resident was observed with two side rails with a therapeutic surface.

The Administrator was not able to provide evidence of the assessment for entrapment zones and confirmed that there were no ongoing or current assessments of the entrapment zones completed for any of the residents who were using the therapeutic surface or the side rails and the bed systems were not evaluated in accordance with evidence based practices. [s. 15. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home furnishings and equipment were kept clean and sanitary.

During an initial tour 28/40 (70%) of the resident rooms were observed and 100% of those rooms were noted to be dirty and dusty and the following were noted:
- a room had black debris around the edges of the room,
- a room had black dirt in the corners behind the doors and under the heater panel,
- a room had a strong urine smell in the room, a build-up of black dirt on the floors, and the privacy curtains were dirty,
- a bathroom had a lingering offensive urine odour and black dirt in the corners of the room,
- a room floor was dirty with black debris and dust in the corners of the room, behind the doors, and the heat covers were dusty,
- a privacy curtain in a room was dirty, and there was dirt build up in the corners of the room,
- a bathroom had a dusty fan and there was black debris in the corners of the room,
- a privacy curtain in a room was dirty, the picture on the wall was dusty, and there was black dirt in the corners of the room and around the edges of the room.

2/2 (100%) of the spa rooms were observed to be dusty and dirty and the following were noted:
- a spa room was observed to have two artificial plants, a heat cover and vent above the tub covered with dust. The floor was dirty with black debris.
- a spa room was observed to have artificial plants, thermostat cover, mirror, and a picture and round air vent covered with dust. The floor of the shower was dirty with black debris and a dried up bar of soap was sitting in a soap dish.

2/2 (100%) of the medication rooms were observed to be dusty and dirty and the following were noted:
- a medication room was noted to have black debris and dust, the sink was dirty, and the door trim was dusty.
- a medication room floor was noted to have black debris and dust build up and the sink was dirty.

4/4 (100%) of common areas were observed to have dirt build-up in the corners and the following were noted:
- a resident common area was noted to have a dried red liquid on the floor, dried brown liquid spots on the floor and dirt in the corners.
- a resident common area was observed to have black dirt built up in corners, coffee stain on the floor, dirt and dust behind the sofas and the small TV lounge had dirt built behind the sofas. [s. 15. (2) (a)]

An observation of the dining rooms revealed the following:
- 3/3 (100%) bases of swivel feeding chairs had a build-up of food/debris
- 4/4 (100%) bases of feeding stools had a build-up of food/debris

A tour of the kitchen revealed the following:
- ceiling vent in front of sliding door fridge was noted to be dusty
- vent above door entering kitchen was noted to be dusty
- add up of food/debris noted on floor by the vinyl baseboard
- two ceiling tiles above the sliding door fridge were noted to be stained

The Director of Food and Support Services confirmed the above findings and shared that the home was in need of cleaning of all resident areas i.e. T.V lounges, SPA rooms, dining rooms and resident's rooms. The expectation was to keep the home, furnishings and equipment clean and sanitary and free from dust. [s. 15. (2) (a)]

2. The licensee failed to ensure that the homes, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During an initial tour of the common areas and resident rooms observation revealed the following maintenance concerns:
- a room with cracked flooring at the entrance and in the middle of the room
- a room with valance curtains off the hooks
- a room with cracked flooring tiles at the foot of the bed and damaged wall near the bathroom
- a room with cracked tiles by the bed
- a room with broken wall protector on the bathroom door and the cracked flooring tiles that were lifting
- a bathroom with a patched wall but not painted,
- a room with cracked flooring in the middle of the room

Observations of the spa room revealed the following:
- 2/2 (100%) of the spa room with cracked flooring, cracked flooring at the base of the toilet and the cracked flooring near the sink and the tub.
- another spa room had cracked flooring by the sink.

Observations of the medication room revealed the following:
- 2/2 (100%) of the medication room with damaged tiles ceiling tiles

- a medication room with a stained ceiling tile and a damaged wall.
- a medication room with a stained ceiling tile, damaged wall and a wall needing painting.

Observation of dining room revealed the following:
- a dining room with a broken lower cupboard near the sink area.

The Maintenance Manager confirmed the above observations and shared that the home is in need of maintenance including painting, wall and furnishing repair to ensure that equipment is maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

A call bell in a resident common area was not accessible for a resident in a wheelchair.
The Administrator confirmed the above observations and reported that the expectation was to have resident response system easily seen, accessed and used by the residents. [s. 17. (1) (a)]

2. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

There was no communication and response system available in the following areas:
- resident lounges
- hairdressing room
- dining rooms and
- therapy room

The Administrator confirmed the above observations and reported that the expectation was to have resident response system in areas accessible by the residents. [s. 17. (1) (e)]

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. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all menu items are prepared according to the planned menu.

During a meal service a resident on a therapeutic diet was served a regular texture diet. The resident choked and required staff to intervene. Review of the clinical notes revealed that the recipe was not followed and the residents on a therapeutic diet were served the regular texture diet.
The Director of Food and Support Services confirmed that menu items were not prepared according to the planned menu. [s. 72. (2) (d)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

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

A resident who was observed with facial hair growth, stated that they wished to have facial hair removed. Staff confirmed that the resident gets bathed twice a week and that the resident was to have facial hair removed during the bath and did not. [s. 3. (1) 4.]

2. The licensee failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

The following were observed during medication pass:
- the Registered Practical Nurse left the medication cart to administer medication to a resident, the screen was left open containing confidential information.
- the Registered Nurse left the medication cart to administer medication to a resident and the screen was left open containing confidential information.
There were three residents sitting close to the medication cart.

The Acting Director of Care confirmed that the expectation was for registered staff to lock the screen and medication cart before leaving the cart to administer medication to afford resident privacy in caring for his or her personal needs. [s. 3. (1) 8.]

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 fully respect and promote the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs and to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

The plan of care for a resident indicated that the resident was to have a rail up when in bed, the clinical records did not indicate the number of bed rails used, and no logo was posted at the head of bed to indicate if the rails were used.
The PSW was asked if resident used bed rails, they indicated that they would have to check the logo above the bed and confirmed that there was no logo posted. The PSW staff indicated that the resident used bed rails when in bed.
The Administrator confirmed that the use of side rails was to be documented in the plan of care to set out clear directions to staff who provide direct care to the residents. [s. 6. (1) (c)]

2. A resident fell out of their bed. Resident had a bed alarm, however, clinical records stated that the bed alarm did not sound at the time of the fall as the bed alarm was not in the proper position. The clinical records identified that the resident had been known to pull the alarm strip out from under the sheet in the past. There were no clear directions in the plan of care to advise staff that the resident removes/readjusts the bed alarm strips causing the bed alarm not to sound.
The Director of Care confirmed that the plan of care does not provide clear direction to the staff to ensure that the bed alarm strips were checked for placement. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care provided to the resident as specified in the plan, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that a resident was not neglected by the licensee or staff.

Two staff members transferred a resident on the commode as part of the toileting schedule and left resident sitting on the commode for extended period of time. Resident was discovered by oncoming staff, no call bell was accessible to resident to alert staff.
A clinical record review and resident interview confirmed that resident had been sitting on the commode for extended period of time and wanted to get off as their back and buttock were sore.
The Administrator confirmed that staff forgot about a resident and failed to provide him/her with care and assistance. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident was not neglected by the licensee or staff, to be implemented voluntarily.

WN #8: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that 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 was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The licensee was unable to provide documentation regarding an annual review of all programs identified in the legislation. The Administrator confirmed that the home was waiting for the corporate policy to come and hence, an annual evaluation and updating of the programs were not completed. [s. 30. (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 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 was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff.

A resident with an impaired skin integrity was assessed by a registered nurse on two occasions.
The Acting Director of Care confirmed that there were no weekly wound assessments done for resident.[s. 50. (2)(b)(iv)]

2. A resident with impaired skin integrity was not reassessed. Clinical record review indicated that there was no weekly reassessment completed for the impaired skin.
The Acting Director of Care confirmed that the resident's impaired skin was not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #10: 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 failed to seek the advice of the Family Council and the Resident Council in developing and carrying out the satisfaction survey, and in acting on its results.

The Family Council Representative and the Resident Council Representative in an interview indicated that they were not made aware of the satisfaction survey and were not consulted in developing or carrying out the surveys. The Administrator confirmed that satisfaction surveys were completed at the time of annual care conferences; however, the Family Council and Resident Council were not consulted in developing and carrying out the surveys. [s. 85. (3)]

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 seek the advice of the Family Council and Resident Council in developing and carrying out the satisfaction survey, and in acting on its results, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

The follwoing were noted during resident's room observation:
- a room had a lingering offensive odour of urine and the bathroom floor was dirty and sticky.
- a room had a strong odour of urine.
During an interview a housekeeping staff indicated that the home used a chemical for lingering offensive odours. The housekeeper shared that it was sprayed on, left to sit, and then washed off. It was used in the resident bathrooms when urine odour was detected.
The Director of Food and Support Services confirmed that rooms had a lingering offensive urine odour. The housekeeping staff shared that although they were using a chemical to assist in controlling these odours, the lingering offensive odour remains. [s. 87. (2) (d)]

Additional Required Actions:

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

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service; O. Reg. 79/10, s. 90 (2).
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and O. Reg. 79/10, s. 90 (2).
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

A resident had a fall from the bed. It was documented that the bed alarm was not working at the time of the fall. Review of the clinical record revealed that the Acting Director of Care entered a note indicating that the fall alarm was placed in the maintenance log for repair. Review of the maintenance logs with the Maintenance Manager revealed no entries related to the fall alarm.
The Maintenance Manager reported that he was not providing repairs to the bed alarm units. [s. 90. (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 procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that a interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who was a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The Administrator confirmed that the pharmacy service provider for the home had changed over one year ago and that a interdisciplinary team meeting had not been conducted to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system since the change over. [s. 116. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who was a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs.

The following observations were noted in the medication room:
-two bottles of expired antacids,
-one bottle of expired iron supplement,
-one bottle of expired asprin,
-four bottles of expired stool softener.
The registered staff confirmed the above expired medications.

The following observations were noted in a another medication room:
-one bottle of expired iron supplement,
-one bottle of expired stool softener,
-one bottle of expired multivitamins
The registered staff confirmed the above observations and reported that the drugs stored in an area or the medication cart should comply with manufacturer's instructions for the storage of the drugs. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart comply with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (5) The licensee shall ensure,
(a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective; O. Reg. 79/10, s. 136 (5).
(b) that any changes identified in the audit are implemented; and O. Reg. 79/10, s. 136 (5).
(c) that a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 136 (5).

Findings/Faits saillants :

1. The Licensee failed to ensure that the drug destruction and disposal system was audited at least annually to verify that the licensee's procedures were being followed and were effective,that any changes identified in the audit were implemented and that a written record was kept.

The Administrator confirmed that there was no annual audit of the drug and disposal system to verify that the licensee's procedures were being followed due to the change over in the pharmacy service provider. [s. 136. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective, that any changes identified in the audit are implemented and a written record is kept of everything provided for in the audit, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 228.
Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents were communicated to the Family Council and or Resident Council.

Interviews with a Family Council Representative and the Resident Council Representative indicated that they were not aware of improvements made through the quality improvement and utilization review system to the accommodation, care, services, programs,and goods provided to the residents. The quality improvement checklist completed by the Administrator, an interview with the Director of Recreation and the meeting minutes all confirmed that improvements made through the quality improvement and utilization review systems were not communicated to both the Family Council and Resident Council. [s. 228. 3.]

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 improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Family Council and or Resident Council, to be implemented voluntarily.

WN #17: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee failed to ensure that the Infection Prevention and Control program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The Administrator confirmed that the Infection Prevention and Control program was not evaluated and updated at least annually as they were waiting for corporate policies. [s. 229. (2) (d)]

2. The Licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

An observation of medication pass revealed that registered staff did not wash hands between administering medications to residents. [s. 229. (4)]

The following were noted during a resident's room observation:
- a resident's night table laminate was scraped off, bedpan was noted sitting on the floor in the bathroom and blue basin was hanging on the towel rack.
- a resident's night table laminate surface was exposed, an unlabeled toothbrush in an

unlabeled cup and a prescription cream labeled with resident's name noted sitting on top of paper towel rack in a shared bathroom.
- an unlabeled mouth wash was noted sitting on top of the towel rack and a unlabeled denture cup, a lotion and a peri-wash were sitting on top of the toilet tank.
- a resident's urinal filled with urine was sitting beside the dresser in resident's room and blue basin was sitting on the floor beside the urinal.

The Acting Director of Care confirmed the observations and shared the expectation for storage of blue ware i.e. basin, denture cup, toothbrush to be stored in residents individual night table and urinal should be emptied and stored in the bathroom. [s. 229. (4)]

The following were noted during a meal observations:
- a staff was observed serving a meal service with gloves on. The staff member touched the food carts, opened the kitchen door, returned trays of dished soups not required to the kitchen and then resumed serving the sandwiches with the same gloves on. When asked about the gloves the staff member stated that they have always worn gloves.
- a staff was observed wearing gloves pushing a resident in their wheelchair. The staff then sat down to feed residents with the same gloves on. When the staff was asked why they were wearing gloves they indicated it was to keep their hands from getting dirty.
- another staff was observed wearing gloves during a meal service. The staff member opened cupboard doors and then picked up sandwiches without changing the gloves.

The Acting Director of Care confirmed that staff were not to wear gloves to feed residents.
The Director of Food and Support Services confirmed that the expectation was that the dietary staff change their gloves prior to serving food if they have utilized their gloves for any other tasks. [s. 229. (4)]

3. The licensee failed to ensure that staff were screened for tuberculosis in accordance with evidence-based practices.

The following were noted during a record review:
- 2/3 staff hired had no evidence on file that they were screened for tuberculosis
- a staff that was hired had a chest x-ray for tuberculosis screening on file dated back to 2009.

3/5 (60%) of the staff records reviewed revealed that they were not screened for tuberculosis in accordance with evidence-based practices.

The Acting Director of Care and the Administrator confirmed these findings and reported that the expectation was to ensure staff were screened for tuberculosis. [s. 229. (10) 4.]

6. The licensee failed to ensure that the pets visiting as part of a pet visitation program have up-to-date immunizations.

The home had a dog visiting as part of the visiting pet program. The dog visited the home once a week. The Director of Recreation confirmed that the home had no immunization records for the dog. [s. 229. (12)]

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 Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to ensure that staff participate in the implementation of the infection prevention and control program,
to ensure that the pets visiting as part of a pet visitation program have up-to-date immunizations, to be implemented voluntarily.

WN #18: 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 failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.

Residents on a therapeutic diet were served the regular texture diet. As a result, a resident choked and required staff to intervene. This incident was not reported to the Director.
The Administrator confirmed that the incident should have been reported immediately to the Director but it was not. [s. 24. (1) 1.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that each resident of the home received fingernail care, including the cutting of fingernails.

The following were noted during an observation:
- a resident was observed to have long dirty fingernails.
In an interview an RPN confirmed that the PSW staff members were responsible for the fingernail care on bath days. [s. 35. (2)]

- a resident was observed to have long jagged and unclean nails. The resident during an interview specified the preference to have short clean nails. The Acting Director of Care and policy NUM -390 Diabetic Care-Nail Care confirmed that nail care for this resident should be completed on bath days by a registered staff. Observations revealed that resident had long dirty nails after the bath.
Registered staff confirmed that no treatment was documented in the clinical record for the resident to ensure resident received fingernail care. [s. 35. (2)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

It was noted that the spa room door was not locked. There was a sign on the door that read "this door is to be kept locked at all times". A disinfectant cleaner was noted sitting on the top shelf. The RN confirmed that the door was not locked and the residents would have access to disinfectant cleaner.
It was confirmed with the Administrator that the Spa room was to be locked at all times. [s. 91.]

Issued on this 11th day of June, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NUZHAT UDDIN (532), DOROTHY GINTHER (568), SHARON PERRY (155), SHERRI GROULX (519)
Inspection No. / No de l'inspection :	2014_271532_0010
Log No. / Registre no:	L000319-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 3, 2014
Licensee / Titulaire de permis :	SAUGEEN VALLEY NURSING CENTER LTD 465 DUBLIN STREET, MOUNT FOREST, ON, N0G-2L3
LTC Home / Foyer de SLD :	SAUGEEN VALLEY NURSING CENTER 465 DUBLIN STREET, MOUNT FOREST, ON, N0G-2L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To SAUGEEN VALLEY NURSING CENTER 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)

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 ensure that each residents 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;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.assess all residents and evaluate their bed systems in all potential entrapment zones for residents where bed rails are used.

Grounds / Motifs :

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

The following were noted during an observation:
- 3/3 (100%) of the residents were observed with one quarter rail and one half rail up.
- a resident was observed with two side rails.
- a resident was observed with two side rails with a therapeutic surface.

The Administrator was not able to provide evidence of the assessment for entrapment zones and confirmed that there were no ongoing or current assessments of the entrapment zones completed for any of the residents who were using the therapeutic surface or the side rails and the bed systems were not evaluated in accordance with evidence based practices. [s. 15. (1)] (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan to achieve compliance with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2)(a) and LTCHA, 2007, S.O. 2007, c.8, s. 15(2)(c) to ensure that the home furnishings and equipment are kept clean and sanitary throughout the home and the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The plan must include what short term and long term action will be undertaken to correct the identified deficiencies as well as who will be responsible to correct the deficiencies and the dates for completion.
Please submit the plan, electronically to Nuzhat Uddin , Long-Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care Performance Improvement and Compliance Branch, 130 Dufferin Avenue 4th floor, London, Ontario, N6A 5R2F, by email at Nuzhat.Uddin@ontario.ca by June 30, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that the home furnishings and equipment were kept clean and sanitary.

An observation of the dining rooms revealed the following:
- 3/3 (100%) bases of swivel feeding chairs had a build-up of food/debris
- 4/4 (100%) bases of feeding stools had a build-up of food/debris

A tour of the kitchen revealed the following:

- ceiling vent in front of sliding door fridge was noted to be dusty
- vent above door entering kitchen was noted to be dusty
- add up of food/debris noted on floor by the vinyl baseboard
- two ceiling tiles above the sliding door fridge were noted to be stained
(155)

2. During an initial tour 28/40 (70%) of the resident rooms were observed and 100% of those rooms were noted to be dirty and dusty and the following were noted:
- a room had black debris around the edges of the room,
- a room had black dirt in the corners behind the doors and under the heater panel,
- a room had a strong urine smell in the room, a build-up of black dirt on the floors, and the privacy curtains were dirty,
- a bathroom had a lingering offensive urine odour and black dirt in the corners of the room,
- a room floor was dirty with black debris and dust in the corners of the room, behind the doors, and the heat covers were dusty,
- a privacy curtain in a room was dirty, and there was dirt build up in the corners of the room,
- a bathroom had a dusty fan and there was black debris in the corners of the room,
- a privacy curtain in a room was dirty, the picture on the wall was dusty, and there was black dirt in the corners of the room and around the edges of the room.

2/2 (100%) of the spa rooms were observed to be dusty and dirty and the following were noted:
- a spa room was observed to have two artificial plants, a heat cover and vent above the tub covered with dust. The floor was dirty with black debris.
- a spa room was observed to have artificial plants, thermostat cover, mirror, and a picture and round air vent covered with dust. The floor of the shower was dirty with black debris and a dried up bar of soap was sitting in a soap dish.

2/2 (100%) of the medication rooms were observed to be dusty and dirty and the following were noted:
- a medication room was noted to have black debris and dust, the sink was dirty, and the door trim was dusty.
- a medication room floor was noted to have black debris and dust build up and

the sink was dirty.

4/4 (100%) of common areas were observed to have dirt build-up in the corners and the following were noted:
- a resident common area was noted to have a dried red liquid on the floor, dried brown liquid spots on the floor and dirt in the corners.
- a resident common area was observed to have black dirt built up in corners, coffee stain on the floor, dirt and dust behind the sofas and the small TV lounge had dirt built behind the sofas.

The Director of Food and Support Services confirmed the above findings and shared that the home was in need of cleaning of all resident areas i.e. T.V lounges, SPA rooms, dining rooms and resident's rooms. The expectation was to keep the home, furnishings and equipment clean and sanitary and free from dust

(519)

3. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During an initial tour of the common areas and resident rooms observation revealed the following maintenance concerns:
- a room with cracked flooring at the entrance and in the middle of the room
- a room with valance curtains off the hooks
- a room with cracked flooring tiles at the foot of the bed and damaged wall near the bathroom
- a room with cracked tiles by the bed
- a room with broken wall protector on the bathroom door and the cracked flooring tiles that were lifting
- a bathroom with a patched wall but not painted,
- a room with cracked flooring in the middle of the room

Observations of the spa room revealed the following:
- 2/2 (100%) of the spa room with cracked flooring, cracked flooring at the base of the toilet and the cracked flooring near the sink and the tub.
- another spa room had cracked flooring by the sink.

Observations of the medication room revealed the following:

- 2/2 (100%) of the medication room with damaged tiles ceiling tiles
- a medication room with a stained ceiling tile and a damaged wall.
- a medication room with a stained ceiling tile, damaged wall and a wall needing painting.

Observation of dining room revealed the following:
- a dining room with a broken lower cupboard near the sink area.

The Maintenance Manager confirmed the above observations and shared that the home is in need of maintenance including painting, wall and furnishing repair to ensure that equipment is maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]
(519)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times and is available in every area accessible by residents.

Grounds / Motifs :

1. 1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

A call bell in a resident common area was not accessible for a resident in a wheelchair.
The Administrator confirmed the above observations and reported that the expectation was to have resident response system easily seen, accessed and used by the residents.
(155)

2. 2. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.
There was no communication and response system available in the following areas:
- resident lounges
- hairdressing room
- dining rooms and
- therapy room

The Administrator confirmed the above observations and reported that the expectation was to have resident response system in areas accessible by the residents. [s. 17. (1) (e)]
(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Order / Ordre :

The licensee shall ensure that all menu items are prepared according to the planned menu.

Grounds / Motifs :

1. The licensee failed to ensure that all menu items are prepared according to the planned menu

During a meal service a resident on a therapeutic diet was served a regular texture diet. The resident choked and required staff to intervene. Review of the clinical notes revealed that the recipe was not followed and the residents on a therapeutic diet were served the regular texture diet.

The Director of Food and Support Services confirmed that menu items were not prepared according to the planned menu. [s. 72. (2) (d)]

(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 05, 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.

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 3rd day of June, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

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