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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 30, 2016	2016_293554_0009	012607-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

THORNTONVIEW
186 THORNTON ROAD SOUTH OSHAWA ON L1J 5Y2

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

KELLY BURNS (554), CAROLINE TOMPKINS (166), MARIA FRANCIS-ALLEN (552), SARAH GILLIS (623)

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): May 16-20, and May 24-25, 2016

The following intakes were reviewed and inspected upon concurrently with the Resident Quality Inspection, #021559-15, 008085-16, 011502-16, 014042-16, 015008-16 and 015434-16.

Summary of Intakes:

1) 021559-15 - Complaint - specific to concerns regarding admission/discharge to the secured unit, medication orders, and altercations between residents.
2) 008085-16 - Complaint - specific to response of staff to call bells and personal resident alarms.
3) 011502-16 - Critical Incident Report - specific to resident to resident abuse, involving resident #042 and #043.
4) 014042-16 - Critical Incident Report - specific to a significant change in resident health status.
5) 015008-16 - Complaint - specific to staffing shortages and care issues as a result of such.
6) 015434-16 - Critical Incident Report - specific to allegation of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Executive Director, Associate Director of Care-RN, Associated Director of Care-RPN, Regional Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeeping Aides, Dietary Aides, Maintenance Staff, Nutritional Manger, Registered Dietitian, Receptionists, Staff Educator-Resident Services Coordinator, RAI Coordinator, Members of the BSO (Behaviour Support) Team, Medical Director, Resident Council Leadership Team Members, President and Co-Chair Family Council, Residents and Families.

During the course of the inspection, the inspector(s) toured the home, reviewed clinical health records for current residents, identified discharged and or deceased residents, observed dining service, observed staff to resident interactions, observed resident to resident interactions, observed activation programs, reviewed minutes of both Resident and Family Council Meetings, reviewed maintenance reporting binders, reviewed home specific investigations for identified Critical Incident Reports, reviewed organizational policies and or procedures relating to, Personal Assistive Service Devices, Least Restraints, Infection Prevention and Control Program, Continence Care, Skin and Wound Care Program, Management of Concerns, Complaints and Compliments, Resident Non-Abuse, and Dementia Care.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During dates of this inspection, the following was observed:

- Flooring – the one sheet laminate flooring was observed to be cracked along the flooring alcoves in spa and shower rooms located on resident home areas, Corbett Court and Trillium Court, as well as the communal washroom within the Rose Garden, resident home area. Water was observed seeping into the sub-flooring in the above identified spa/shower rooms.

- Flooring - tiled floors - were observed cracked and or chipped in identified resident rooms; one piece laminate flooring in a adjoining resident washroom was observed cracked around the flooring drain. Flooring tile in a specific resident room was observed partially missing with exposed sub-flooring, visible debris was observed to this area.

- Flooring Tiles - observed separating with dark brownish-black debris between flooring tiles, in identified resident rooms.

- Shower Stall – ceramic tiled flooring of the shower stall was observed chipped around the floor drain. This shower is located within the Rose Garden, resident home area.

- Walls - gouged, scuffed or having wall damage observed along wall edges in identified resident rooms and washrooms, as well as visible corner steel beading exposed in areas identified.

- Wall Guard - missing in areas along the wall in two resident rooms.

- Door - wooden door observed gouged, and chipped in identified resident rooms; the door in one resident room was observed to have jagged and sharp edges along door frame.

The maintenance binders located on resident home areas were reviewed and failed to identify repairs required for the above identified walls, wall guards, and doors.

Personal Support Worker #134 and Registered Practical Nurse #103 indicated that any identified maintenance concerns are to be placed into the maintenance reporting binders, which are located on all resident home areas.

According to a Maintenance Staff and the Regional Manager the Corbett Court spa room is scheduled to have flooring renovations before the end of July 2016. Regional Manager indicated speaking with the Executive Director, and as of this date there were no flooring repairs or replacement scheduled for the remaining three spa/shower rooms and or resident rooms. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: 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 comply with LTCHA, 2007, s. 24 (1), by not ensuring person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically abuse of a resident by anyone.

Related to Intake #011502-16:

The Associate Director of Care submitted a Critical Incident Report to the Director, on a identified date, specific to a alleged abuse incident which was said to have occurred approximately twenty-four hours earlier and involved resident #042 and #043.

The clinical health record was reviewed for residents #042 and #043, for a specific date and provided the following details of the said incident.

Personal Support Worker (PSW) #136 was in the dining room, heard resident #042 and #043 arguing and turned around to see what was happening; PSW #136 indicated he/she witnessed resident #042 exhibit a specific responsive behaviour towards resident #043. PSW #136 indicated he/she witnessed resident #043 fall. Resident #043 complained of discomfort. Resident #043 continued to complain of discomfort, despite an analgesic being administered; resident #043 was later transferred to hospital for assessment and treatment of injuries sustained during the witnessed incident.

Personal Support Worker #136 indicated that the incident between resident #042 and #043 would be considered verbal/physical abuse. PSW #136 indicated the witnessed incident between the two residents was reported to Registered Practical Nurse (RPN) #131.

Registered Nurse (RN) #132 indicated working a specific shift, on the identified date, when the incident was said to have occurred, and acknowledged being told of the resident to resident incident by RPN #131 that same shift. RN #132 indicated that the said incident would be considered both verbal and physical abuse.

Registered Nurse #132, who was the designated charge nurse, indicated the resident to resident abuse incident was not reported to the Director (Ministry of Health and Long-Term Care) as he/she was not aware that reporting of abuse of a resident was a requirement of his/her role as a Charge Nurse, and further commented that he/she had

no awareness of the legislative requirement for reporting resident abuse.

Executive Director indicated that RN #132 had received direction upon hire as to prevention, and reporting of resident abuse. The Executive Director and Associated Director both indicated that the expectation is that abuse of a resident by anyone is immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that there is a process in place and monitored to ensure that abuse of a resident by anyone is immediately reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 31 (3) (d), by not ensuring the staffing plan, includes a back-up plan for nursing and personal care staffing to address situations when staff cannot come to work.

Under LTCHA, 2007, s. 8, every licensee of a long-term care home shall ensure that there is an organized program of nursing services for the home to meet the assessed needs of the residents; and an organized program of personal support services for the home to meet the assessed needs of the residents.

Related to Intake #015008-16:

During dates of this inspection, staff and family indicated that the long-term care home is frequently short staffed, specifically when the home is unable to cover staff sick calls.

Personal Support Workers #117, and #119, Registered Nurse #118, and the Associate Director of Care all indicated no awareness of a back-up staffing plan to address times when the long-term care home is short staffed.

The Regional Manager, as well as the Administrator both acknowledged that there is no back up staffing plan for nursing and personal care to address situations when the home is short staffed. [s. 31. (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 ensuring the staffing plan, includes a back-up plan for nursing and personal care staffing to address situations when staff cannot come to work, to be implemented voluntarily.

WN #4: 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 comply with O. Reg. 79/10, s. 87 (2) (d), by not ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours.

During dates of this inspection, the following odours were identified:

- An identified resident room – a shared (semi) washroom was identified on May 16, 2016 (at approximately 1100, and 1400 hours), on May 17, 2016 (at approximately 0815, 1200 and 1430 hours), as well as May 18-19, 2016 (at approximately 0800, 1200 and 1440 hours) to have a strong and lingering odour, that resembled the smell of urine. This washroom is shared with an adjoining resident room, which is located on Rose Garden, resident home area. This room was observed to have an identified fluid on the floor surrounding the toilet.

- An identified resident room – shared (semi) washroom was identified on May 16, 2016 (at approximately 1100, and 1400 hours), on May 17, 2016 (at approximately 0815, 1200 and 1430 hours), as well as May 18-19, 2016 (at approximately 0800, 1200, and 1440 hours) to have a strong and lingering odour, that resembled the smell of urine. This washroom is shared with an adjoining resident room, which is located on Rose Garden, resident home area. This room was observed to have dark staining around the base of the toilet and the surrounding floor.

- An identified resident room – shared (semi) room was identified on May 24, 2016 (at approximately 0840 and 1400 hours) to have a strong and lingering odour, that resembled the smell of urine.

- An identified resident room – shared (basic) room was identified on May 16-17, 2016 and May 18, 2016 (at approximately 1000, 1400 hours) to have a strong and lingering odour, which resembled the smell of body odour and urine.

- Communal Washroom – was identified on May 17, 2016 at approximately 0815, 1200 and 1430 hours), as well as May 18-19, 2016 (at approximately 0800, 1200, and 1440 hours) to have a strong and lingering odour, that resembled the smell of urine. This room was observed to have an identified fluid on the floor surrounding the toilet. This washroom is located adjacent to the main dining room.

- Spa Rooms - on both Rose Garden and Pine Grove, resident home areas, were identified to have a strong and lingering odour, which resembled fecal matter during dates of this inspection. Soiled incontinence products were observed sitting in open garbage containers in the said spa rooms. It is to be noted that this room is used not only for bathing and shower, but is also used for scheduled toileting of residents.

Personal Support Worker (PSW) #109 indicated that the urine-like odour in the identified resident washrooms is always present; PSW indicated he/she believed that the odour is a result of resident's urinating on the washroom floors.

Housekeepers indicated that soiled incontinence products being left in spa rooms is a contributing factor to odours within these rooms.

Housekeeping Aide (HSKA) #112, who works on an identified resident home area, indicated that the only procedure in place for addressing lingering and offensive odours is daily cleaning using a combination spray which cleans and disinfects. HSKA #112 indicated if odours are identified, then he/she would also use a spray air freshener to mask the odour, which would be a short term measure. HSKA #112 indicated no awareness of any lingering offensive odours on the resident home area as of this date.

Housekeeping and Maintenance Staff, as well as the Associate Director of Care and the Regional Manager, all indicated that the long-term care home currently has no policy or procedures in place to address lingering offensive odours. [s. 87. (2) (d)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 98, by not ensuring the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Related to Intake #011502-16:

The clinical health record was reviewed for residents #042 and #043, for a specific date and provided the following details of the said incident:

Personal Support Worker (PSW) #136 was in the dining room, heard resident #042 and #043 arguing and turned around to see what was happening; PSW #136 indicated he/she witnessed resident #042 exhibit a specific responsive behaviour towards resident #043. PSW #136 indicated he/she witnessed resident #043 fall. Resident #043 complained of discomfort. Resident #043 continued to complain of discomfort, despite an analgesic being administered; resident #043 was later transferred to hospital for assessment and treatment of injuries sustained during the witnessed incident.

Registered Nurse (RN) #132 indicated working the identified shift, on a said date, when the abuse incident was said to have occurred, and acknowledged being told of the resident to resident incident by RPN #131 that same shift. RN #132 indicated that the said incident would be considered both verbal and physical abuse.

Registered Nurse #132,. who was the designated charge nurse, indicated the police were not called when the resident to resident abuse incident took place.

Executive Director and the Associate Director of Care indicated police were not notified of the resident to resident abuse incident, which resulted in injury to resident #043 until the next business day. Executive Director indicated RN #132 should have notified the police of the incident on specific shift following the alleged abuse incident. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring there is a process in place and monitored to ensure the appropriate police force is immediately notified of alleged, suspected or witnessed incidents of abuse, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229 (4), by not ensuring staff participate in the implementation of the infection prevention and control program.

During dates of this inspection, the following was observed:

- An identified resident room – a bedpan was observed sitting on the washroom floor, beside the toilet, a second bedpan was observed on back of toilet; both items were unlabelled in a shared washroom. Both bedpans were observed to contain a dried brownish substance in the bottom of the bedpans. This washroom is shared with the adjoining resident room, which is also a semi accommodation. Note: A sign was on the door of this room indicated Contact Precautions to be in place

- An identified resident room – a bedpan was observed on back of toilet, in a shared washroom; the item was unlabelled. The bedpan was used and contained a dried brownish substance within the bottom of the bedpan. This washroom is also shared with adjoining room which is also a semi accommodation.

- An identified resident room – a bedpan was observed on the on back of toilet; the item was not labelled. This is a shared washroom and adjoins to the next resident room,

which is a semi accommodation.

- An identified resident room – a urinal was observed sitting on the floor by toilet in a shared washroom; this item was unlabelled. This washroom is shared with the adjoining resident room, which is also a semi accommodation.

- An identified resident room – a urine collection device was observed in a shared washroom, the item was unlabelled. This washroom is also shared with the adjoining room.

- An identified resident room – a urine collection device was observed in a shared washroom on the floor; the item was used and unlabelled. This washroom is also shared with the adjoining room.

- An identified resident room – used urinals were observed on the counter top in a shared (basic) washroom; items were unlabelled.

- An identified resident room – a bedpan was observed on the back of toilet, and a urine collection device (hat) was observed on the shelf in the washroom; the urine collection device was unlabelled.

- An identified resident room – a urine collection device (hat) was observed lying upside down on a towel on top of the washroom counter upside down lying on a towel; the item was unlabelled.

- Spa Room – a urinal containing a yellow substance was observed hanging on a toileting hand rail in a communal spa room; the item was unlabelled. This room was located within the Rose Garden, resident home area.

Personal Support Worker #134 and Registered Practical Nurse #103 indicated that bedpans and urinals are to be labelled for individual use and cleaned following usage in the white racks in resident washrooms. Nursing Staff indicated bedpans and urinals are not to be placed on washroom floors. Both staff indicated urine collection devices (hats) are for single use only and are to be disposed of after usage.

The Associate Director of Care, who is the lead for the homes Infection Control Program, as well as the Regional Manager, indicated that bedpans and urinals are to be labelled for individual resident usage and are not to be left clean or soiled on washroom floors, as

such poses a potential risk of infections. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring there is a process in place and monitored to ensure all staff participate in the infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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 comply with LTCHA, 2007, s. 6 (1) (c), by not ensuring there is a written plan of care for each resident that sets out ,clear directions to staff and others who provide direct care to the resident related to toileting and continence for resident #015.

Review of the plan of care, dated for a specific time period, indicated resident #015 does not require a toileting program and has daily bladder and bowel incontinence, as evidenced by, incontinent due to physical limitations, cognitive impairment, laxative use. Interventions include:
- provide toileting upon request
- see toileting focus for level of assistance required for further interventions
- see Prevail list for current continence care product(s) used
- check with resident & record if he/she has had BM and has voided
- report to Nurse if has not voided this shift
- report to Nurse any changes in urinary characteristics, amount, color, frequency or odour
- record BM - Note size and consistency
- report any abnormalities to Nurse

The current written plan of care does not include a toileting focus for reference.

Personal Support Worker (PSW) #105 he/she indicated that resident #015 is no longer toileted by staff, resident #015 is placed onto his/her bed using the maxi lift and his/her continence product is changed. Resident #015 is not capable of telling staff that he/she needs to use the bathroom and has been totally incontinent and not toileted for approximately six months. PSW#105 indicated that he/she would reference the kardex in the Point of Care (POC) tablet for the most current information on how to care for a resident.

The written plan of care for resident #015 was reviewed for a specific period and failed to provide direction as to toileting and or continence care required for resident #015.

The RAI-Coordinator confirmed that the written plan of care did not contain clear directions, specific to toileting and or continence care required for resident #015. [s. 6. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s.14, by not ensuring each resident shower has a least two easily accessible grab bars, one grab bar located on the same wall as the faucet and one grab bar located on the adjacent wall.

The shower stall, located within the Rose Garden resident home area, was identified to not have an accessible shower grab bars, specific to legislative requirements. The shower stall did not have an accessible shower grab bar on the wall adjacent wall to the faucet wall.

Maintenance Staff indicated that the shower stall in Rose Garden had been renovated at some point in November 2015 and the shower grab bar must not have been re-installed. [s. 14.]

Issued on this 30th day of May, 2016

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

Original report signed by the inspector.