Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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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
Apr 29, 2013	2013_189120_0026	H-000139-13/H-000144-13	Complaint

Licensee/Titulaire de permis

VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR
302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - TULLAMORE
133 KENNEDY ROAD SOUTH, BRAMPTON, ON, L6W-3G3

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 16 & 17, 2013

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, registered and non-registered staff, maintenance person and residents.

During the course of the inspection, the inspector(s) toured the home, including the basement, bathing rooms, resident rooms, washrooms and common areas, measured lighting levels, observed and tested resident bed rails and mattresses, reviewed maintenance documents and health and safety reports.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 :

Where bed rails are used, residents have not been assessed and their bed systems evaluated in accordance with evidence-based practices or prevailing practices (Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", 2008), to minimize risk to the resident.

Upon touring the home, some bed systems were observed to be in a condition that may pose risks to residents, specifically entrapment risks. A number of residents were noted to be lying in bed with quarter assist rails in place. Bed mattresses were noted to be either too long or too short for the bed frames. Mattresses that are too short create excessive gaps at the head or foot of the bed (entrapment zone 7). Mattresses that are too long can bunch in the center and may not lie flat. A number of beds had missing mattress keepers or did not have any mattress keepers to keep the mattresses from sliding side to side. When beds without mattress keepers were tested, the mattresses easily slid off the frame of the bed, especially when the bed rail was not on the bed frame. Several therapeutic surfaces were also noted in a room which have inherent entrapment risks based on their design (soft edges, height and compressible nature). A mixed variety of new and old bed models were noted, and some older bed models were observed to have new quarter length assist bed rails on the frames and some without bed rails. The maintenance person confirmed that the older beds did in fact have their old full or 3/4 length bed rails removed and replaced with a quarter rail within the last year and that some have been completely removed. The home has not conducted any evaluations of the bed systems or assessments of the residents to determine if any of the changes to the beds meet the Health Canada guidelines. [s.15(1(a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The home was not found to be a safe environment for residents on April 16 & 17, 2013.

During the inspection, furniture such as chairs and tables were observed to be positioned across several corridors and in doorways to a large common seating area, thereby causing obstructions. The reason provided for the set-up was for enteric outbreak purposes, to prevent residents from wings 1 and 2 mingling with residents from wings 3 and 4.

For infection control purposes, blocking whole corridors and rooms with furniture is not permitted, considering the concern for ease of egress in an emergency and violation of resident's rights to move freely within their home. Control measures for an enteric outbreak include hand washing, cohorting staff, personal protective equipment and more frequent cleaning and sanitizing of touch point surfaces, which the Director of Care identified was already being done. [s. 5.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table.

Findings/Faits saillants :

Lighting requirements as set out in the lighting table are not being maintained.

Random resident rooms and washrooms and tub/shower rooms were measured with a Sekonic Handy Lumi light meter. The meter was held at chest height and at waist height directly under the ceiling lights (where provided).

* Resident bedrooms have not been provided with any overhead lighting to ensure that the minimum lighting level of 215.84 is maintained. In order to emulate night time conditions, the curtains were drawn and the bedrooms were between 0 and 10 lux. Resident rooms can only be lit using resident's individual over bed lights which only light the area above the head of the bed. The illumination levels from the over bed lights does not impact the level of the room lighting.

* Resident ensuite washrooms either have one or two ceiling fixtures, depending on the size and configuration of the room. The fluorescent light bulbs are covered with opaque glass. Bathroom #54 has one light fixture which was noted to be 90 lux, directly under the light fixture. Bathrooms #67 and #51 each have two light fixtures however in each case, only one light was working. The lights over the sinks were not functional. The lux under the light in #67 was 40 and the lux in #51 was 20. Where both lights were functional (#56), the lux was 100 under each light fixture for a general room lux of 100. The minimum required lighting level is 215.84.

* Tub/shower rooms were noted to have two types of lighting, a ceiling mounted heat lamp with three bulbs (generally used in the winter months for additional warmth) and ceiling mounted fixtures similar to those in resident washrooms. The enclosed shower area located in wing 1 has no light fixture over the centre of the shower, only near the entrance. The lux is 0 inside the shower and approximately 90 under the fixture near the entrance. The tub room next to the shower area has a light fixture over the tub, which was 100 lux, however the light meter was also affected by the additional light (sun) coming in from the outside through shears on the window. Night time conditions could not be replicated. The other three tub/shower rooms are configured differently from the tub/shower room in wing 1. They do not have a separately enclosed shower area, but are open to the room which contains the tub. The tub/shower room located in wing 2 was measured with and without the heat lamp lighting. With the heat lamp on, the lux was over 1000 directly under the light, and the level would drop to below 50 lux towards the edges of the room. The other two light fixtures in the room were only capable of providing 20 and 50 lux. Again, the outdoor light was affecting the

Lighting requirements as set out in the lighting table are not being maintained.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control
Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

Immediate action to deal with pests, specifically drain flies has not been taken.

Drain flies were observed on the tiled walls of the shower surround in Wing 1 of the home on April 16, 2013. The shower surround was noted to have some caulking around the perimeter, along some tiles. The caulking was very wet, loose and growing some mould. The shower hose was continuously leaking. The conditions were noted to be ideal for drain flies to breed either inside of the drain or behind the shower surround which may not be water tight. It is uncertain as to the actual breeding site of the flies without further investigation.

An employee who works in this shower room daily stated that when they arrive first thing in the morning, there is a cloud of files throughout the shower area. The employee stated that it has been an ongoing problem for several years. The maintenance person stated that he became aware of the problem approximately a week. His actions to date have been to pour a liquid product down the drain, which has not resolved the problem. The maintenance person had not contacted their pest control operator, which the home has a contract with to get advice or assistance. The administrator confirmed that their pest control operator has not been called in to respond to this matter. [s. 88(2)]

Issued on this 29th day of April, 2013

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

B Sosnik

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) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2013_189120_0026
Log No. / Registre no:	H-000139-13/H-000144-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 29, 2013
Licensee / Titulaire de permis :	VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR 302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - TULLAMORE 133 KENNEDY ROAD SOUTH, BRAMPTON, ON, L6W-3G3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ASTRIDA KALNINS

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to address the following:

1. When will all bed systems be evaluated and residents assessed?
2. Who will conduct the bed system evaluations and resident assessments?
3. What immediate and long-term actions will be taken with respect to bed systems that have failed any of the 7 entrapment zones and/or have been identified with other safety issues?
4. What immediate actions will be taken with respect to resident safety where an entrapment zone has been identified as non-compliant?

The written plan shall be submitted by email to Bernadette.Susnik@ontario.ca or by mail to Bernadette Susnik, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care Improvement and Compliance Branch, 119 King St. W., 11th floor, Hamilton, ON L8P 4Y7 by May 31, 2013.

Grounds / Motifs :

1. Where bed rails are used, residents have not been assessed and their bed systems evaluated in accordance with evidence-based practices or prevailing practices (Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", 2008), to minimize risk to the resident.

Upon touring the home, some bed systems were observed to be in a condition that may pose risks to residents, specifically entrapment risks. A number of residents were noted to be lying in bed with quarter assist rails in place. Bed mattresses were noted to be either too long or too short for the bed frames. Mattresses that are too short create excessive gaps at the head or foot of the bed (entrapment zone 7). Mattresses that are too long can bunch in the center and may not lie flat. A number of beds had missing mattress keepers or did not have any mattress keepers to keep the mattresses from sliding side to side. When beds without mattress keepers were tested, the mattresses easily slid off the frame of the bed, especially when the bed rail was not on the bed frame. Several therapeutic surfaces were also noted in a room, which have inherent entrapment risks based on their design (soft edges, height and compressible nature). A mixed variety of new and old bed models were noted, and some older bed models were observed to have new quarter length assist bed rails on the frames and some without bed rails. The maintenance person confirmed that the older beds did in fact have their old full or 3/4 length bed rails removed and replaced with a quarter rail within the last year and that some have been completely removed. The home has not conducted any evaluations of the bed systems or assessments of the residents to determine if any of the changes to the beds meet the Health Canada guidelines. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2013

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

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

and the Director

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

Issued on this 29th day of April, 2013

Signature of Inspector / Signature de l'inspecteur : B. Susnik

Name of Inspector / Nom de l'inspecteur : BERNADETTE SUSNIK

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