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
Aug 15, 2013	2013_207147_0010	H-000313-13	Critical Incident System

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF ERIN MEADOWS
2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4

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

LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 18, 19, 23, 24 and 26, 2013

H-000313-13
H-000351-13
H-000426-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Physician, Neighbourhood Coordinators, Registered staff, Resident Assessment Instrument (RAI) Coordinator, Personal Support Workers (PSW) and families.

During the course of the inspection, the inspector(s) toured the home, reviewed home's policy and procedures, resident's electronic and hard clinical charts, staff personnel files and home's internal investigation notes.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

Safe and Secure Home

Skin and Wound Care

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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (1) The skin and wound care program must, at a minimum, provide for the following:
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents. O. Reg. 79/10, s. 50 (1).

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

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 the skin and wound program provide strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.

Review of the home's current skin and wound program and interview with the DOC confirms that the home does not have a policy and procedure related to providing strategies to promote residents comfort and promote the prevention of infection, including the monitoring and managing residents with surgical wounds. [s. 50. (1) 2.]

2. The licensee failed to ensure the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Resident #103 was sent to hospital in May 2013 for surgery and returned to the home several days later. Review of the resident's clinical chart, progress notes and interview with the registered staff confirmed that a skin assessment by a member of the registered nursing staff was not completed upon the resident's return from the hospital. Subsequently, there was no further skin assessment completed by the registered staff. There was no follow up by the physician related to further orders until when the resident was readmitted back to the hospital related to signs and symptoms of infection. [s. 50. (2) (a) (ii)]

3. The licensee failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Resident #103 was sent to hospital in May 2013 for surgery and returned to the home several days later. Review of the resident's clinical chart, progress notes, doctor's orders, Medication Administration Records (MARs) and Treatment Administration Records (TARs), and interview with the registered staff and physician confirmed that the resident did not receive immediate treatment and intervention to reduce or relieve pain, promote healing and prevent infection post surgery. [s. 50. (2) (b) (ii)]

Additional Required Actions:

CO # - 001, 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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,
(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).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(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).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(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 are developed and implemented to ensure that 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.

Review of the water temperature logs on two home areas and interview with the registered staff confirmed that the water temperatures in the shower areas for the month of June and July 2013 did exceed 49 degrees celsius. The water temperature were not consistently documented on the "Water Temperature Recording Sheet" and the documented temperatures varied between 51 to 52 degrees celsius in the home area spas and resident room basins. [s. 90. (2) (g)]

2. The licensee failed to ensure immediate action was taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

Temperature logs kept by the registered staff for two home areas verify recording of water temperatures of over 49 degrees celsius. The temperature logs contain a column labeled "Follow Up", however, the temperatures logs recorded at above 49 degrees celsius did not have any follow up actions consistently recorded on the forms, as required by the home's policy and procedure. [s. 90. (2) (h)]

3. The licensee failed to ensure that procedures are developed and implemented to ensure that 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.

The home's current Hot Water Temperature Recording policy and procedure (#06-18) stated, the Registered nurse in Charge of the building will take hot water temperatures at resident accessible faucets once on each shift daily and record the findings on the Hot Water Temperature logs and ensuring follow up action is taken and documented in the "Follow Up" column on the form when temperatures exceed 49 degrees celcius or go below 40 degrees celcius.

Review of the Water Temperature Recording sheets for June and July 2013 and interview with the DOC and the administrator revealed that the water temperatures recorded for the month of June, 2013 were documented as between 50 - 60 degrees celcius for 27 days out of the month with no follow up comments made on the

recording sheet until June 26, 2013. Interview with the Environmental manager did confirm that the water valves were replaced on June 27, 2013, however the water temperatures after the replacement for the remainder of June and July, 2013 continued to show the water temperatures fluctuate to as high as 55 degrees celcius and as low as 27 degrees celcius with no follow up comments made on the recording sheets until July 17, 2013. [s. 90. (2) (k)]

Additional Required Actions:

CO # - 004 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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: Staff apply the physical device in accordance with any manufacturer's instructions.

Interview with the staff and review of the home's internal investigation confirmed that in June 2013 resident #102 was transferred to bed by two PSWs, then one PSW continued to provide care for the resident. As per the resident's current plan of care and interview with the staff on the unit, the resident requires two bedrails up while in bed for safety.
According to the manufacturers instruction for Manual Echo Bed - 1-150-006-M - Carroll Healthcare Inc. - related to the side rail operation - the staff are to ensure "An audible "click" can be heard when the UP position is reached".
The PSW left the resident unattended and could not recall ensuring the bed rails were in a lock position in accordance with the manufacturer's instructions before leaving the resident. Upon return to the resident's room, the resident had fallen out of bed and was then sent to hospital further assessment and was diagnosed with an injury. [s. 110. (1) 1.]

2. The licensee failed to ensure that he following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

Interview with the PSWs and DOC confirmed that the home was not monitoring resident #102 restraint at least every hour every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
According the resident's plan of care and interview with the staff on the unit, the resident requires two full length bed rails up while in bed for safety. However, the staff were not documenting and monitoring the restraint every hour for the past two months. DOC states that the staff were using the wrong form which did not include hourly monitoring, but instead using the two hour repositioning form. [s. 110. (2) 3.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 the residents are monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure the care set out in the plan of care was provided to resident #101 as specified in the plan.

Review of the resident #101 plan of care, Resident Assessment Protocol for the past three quarters and interview with the staff indicate the resident is a total mechanical lift and requires total assistance of two staff for all hygiene related tasks and showers. Interview with the PSW, who provided direct care to the resident and review of the internal investigation notes confirmed that the PSW requested assistance from another psw to transfer the resident from bed to shower chair, wheeled the resident into the shower room and provided care to the resident without the assistance of a second PSW. [s. 6. (7)]

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 the care set out in the plan of care was provided to resident #101 as specified in the plan, to be implemented voluntarily.

WN #5: 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 failed to ensure that residents #101 and #103 were neglected by the licensee or staff.

A. Resident #101 was diagnosed with an injury in July 2013 which occurred while being showered by the staff. Interview with the environmental manager and review of the Hot Water Temperature logs for June and July 2013 indicated the water temperatures in the home were fluctuating above 49 degrees celcius, some days in excess of 60 degrees celcius. Interview with the Administrator, DOC and Environmental Manager confirm that a memo was sent out to the staff on the units in July 2013, but there were no earlier communication provided to the front line staff related to any precautionary measures to be put in place for the water fluctuations when the home was aware of the issue in early June, 2013.

B. Resident #103 was sent to hospital in May 2013 for surgery and returned to the home several days later. Review of the resident's clinical chart, progress notes and interview with the registered staff confirmed that a skin assessment by a member of the registered nursing staff was not completed upon the resident's return from the hospital. Subsequently, there was no further skin assessment completed by the registered staff and no follow up to the physician related to orders until when the resident was readmitted back to the hospital related to signs and symptoms of infection. [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 the licensee shall that all residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #103 returned from hospital in June 2013 and re-admission orders were confirmed by the physician which included anti-coagulants twice daily. Review of the resident's June, 2013 Medication Administration Records (MAR) and interview with registered staff and DOC, confirmed that the home had ran out of the medication.

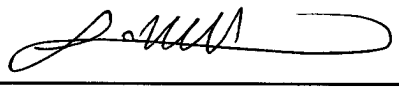
According to the documentation on the June 2013 MARs the resident was not administered two doses of the anti-coagulant according with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber., to be implemented voluntarily.

Issued on this 3rd day of September, 2013

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LALEH NEWELL (147)
Inspection No. / No de l'inspection :	2013_207147_0010
Log No. / Registre no:	H-000313-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 15, 2013
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF ERIN MEADOWS 2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anneliese Krueger

To OAKWOOD RETIREMENT COMMUNITIES INC., 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. 50. (1) The skin and wound care program must, at a minimum, provide for the following:
1. The provision of routine skin care to maintain skin integrity and prevent wounds.
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.
4. Treatments and interventions, including physiotherapy and nutrition care. O. Reg. 79/10, s. 50 (1).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that the skin and wound program to include policy and procedure related to providing strategies to promote residents comfort and promote the prevention of infection, including the monitoring and managing residents with surgical wounds.

The plan is to be submitted by August 30, 2013 to Long Term Care Homes Inspector
Laleh Newell at: Laleh.Newell@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure the skin and wound program provide strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.

Review of the home's current skin and wound program and interview with the DOC confirms that the home does not have a policy and procedure related to providing strategies to promote residents comfort and promote the prevention of infection, including the monitoring and managing residents with surgical wounds. [s. 50. (1) 2.] (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that all residents exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

The plan is to be submitted by August 30, 2013 to Long-Term Care Homes Inspector
Laleh Newell at: Laleh.Newell@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Resident #103 was sent to hospital in May 2013 for surgery and returned to the home several days later. Review of the resident's clinical chart, progress notes and interview with the registered staff confirmed that a skin assessment by a member of the registered nursing staff was not completed upon the resident's return from the hospital. Subsequently, there was no further skin assessment completed by the registered staff. There was no follow up by the physician related to further orders until when the resident was readmitted back to the hospital related to signs and symptoms of infection. [s. 50. (2) (a) (ii)] (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The plan is to be submitted by August 30, 2013 to Long-Term Care Homes Inspector
Laleh Newell at: Laleh.Newell@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Resident #103 was sent to hospital in May 2013 for surgery and returned to the home several days later. Review of the resident's clinical chart, progress notes, doctor's orders, Medication Administration Records (MARs) and Treatment Administration Records (TARs), and interview with the registered staff and physician confirmed that the resident did not receive immediate treatment and intervention to reduce or relieve pain, promote healing and prevent infection post surgery. [s. 50. (2) (b) (ii)] (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(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;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(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;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(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;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(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;

(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

(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).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that 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, immediate action taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius and that procedures are developed and implemented to ensure that 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.

The plan is to be submitted by August 30, 2013 to Long-Term Care Homes Inspector
Laleh Newell at: Laleh.Newell@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that procedures are developed and implemented to ensure that 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.

Review of the water temperature logs on two home areas and interview with the registered staff confirmed that the water temperatures in the shower areas for the month of June and July 2013 did exceed 49 degrees celsius. The water temperature were not consistently documented on the "Water Temperature Recording Sheet" and the documented temperatures varied between 51 to 52 degrees celsius in the home area spas and resident room basins. [s. 90. (2) (g)] (147)

2. The licensee failed to ensure immediate action was taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

Temperature logs kept by the registered staff for two home areas verify recording of water temperatures of over 49 degrees celsius. The temperature logs contain a column labeled "Follow Up", however, the temperatures logs recorded at above 49 degrees celsius did not have any follow up actions consistently recorded on the forms, as required by the home's policy and procedure. [s. 90. (2) (h)] (147)

3. The licensee failed to ensure that procedures are developed and implemented to ensure that 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.

The home's current Hot Water Temperature Recording policy and procedure (#06-18) stated, the Registered nurse in Charge of the building will take hot water temperatures at resident accessible faucets once on each shift daily and record the findings on the Hot Water Temperature logs and ensuring follow up action is taken and documented in the "Follow Up" column on the form when temperatures exceed 49 degrees celcius or go below 40 degrees celcius.

Review of the Water Temperature Recording sheets for June and July 2013 and interview with the DOC and the administrator revealed that the water temperatures recorded for the month of June, 2013 were documented as between 50 - 60 degrees celcius for 27 days out of the month with no follow up comments made on the recording sheet until June 26, 2013. Interview with the Environmental manager did confirm that the water valves were replaced on June 27, 2013, however the water temperatures after the replacement for the remainder of June and July, 2013 continued to show the water temperatures fluctuate to as high as 55 degrees celcius and as low as 27 degrees celcius with no follow up comments made on the recording sheets until July 17, 2013. [s. 90. (2) (k)] (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 20, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall ensure that with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act, Staff apply the physical device in accordance with any manufacturer's instructions.
The plan is to be submitted by August 30, 2013 to Long-Term Care Homes Inspector Laleh Newell at: Laleh.Newell@ontario.ca

Grounds / Motifs :

1. 1. The licensee failed to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: Staff apply the physical device in accordance with any manufacturer's instructions.

Interview with the staff and review of the home's internal investigation confirmed that in June 2013 resident #102 was transferred to bed by two PSWs, then one PSW continued to provide care for the resident. As per the resident's current plan of care and interview with the staff on the unit, the resident requires two bedrails up while in bed for safety.
According to the manufacturers instruction for Manual Echo Bed - 1-150-006-M - Carroll Healthcare Inc. - related to the side rail operation - the staff are to ensure "An audible "click" can be heard when the UP position is reached".
The PSW left the resident unattended and could not recall ensuring the bed rails were in a lock position in accordance with the manufacturer's instructions before leaving the resident. Upon return to the resident's room, the resident had fallen out of bed and was then sent to hospital further assessment and was diagnosed with an injury. [s. 110. (1) 1.] (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 20, 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 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 15th day of August, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LALEH NEWELL

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