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

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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
Feb 22, 2016	2015_405189_0017	024207-15	Resident Quality Inspection

Licensee/Titulaire de permis

INA GRAFTON GAGE HOME OF TORONTO
40 Bell Estate Road SCARBOROUGH ON M1L 0E2

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

INA GRAFTON GAGE HOME
40 Bell Estate Road SCARBOROUGH ON M1L 0E2

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

NICOLE RANGER (189), JOELLE TAILLEFER (211), SARAN DANIEL-DODD (116), THERESA BERDOE-YOUNG (596)

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): September 15, 16, 17, 18, 28, 29, 30, October 1, 2, 5, 6, 7, November 13, 2015.

The following Complaints inspections were conducted concurrently with this RQI:017391-15, 003166-15, 006651-14, 005986-14, 005678-14.
The following Critical Incident inspections were conducted concurrently with this RQI: 018538-15, 015856-15, 008505-15, 003486-15.
The following Follow up inspections were conducted concurrently with this RQI: 011025-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Nursing Consultant, Director of Support Services, Registered Dietitian (RD), Physiotherapist (PT), Programs and Service Manager, Manager of Clinical Informatics, Staffing Clerk, environmental service lead, registered staff, personal support workers, dietary aide, food service workers, housekeeping aide, private sitter, Residents' Council Chair and Co-chair, Family Council Chair and Family Council Co-chair, residents and family members.

The inspectors conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of clinical health records, complaint record log, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 31. (3)	CO #003	2014_378116_0014	116
O.Reg 79/10 s. 51. (2)	CO #001	2014_378116_0014	116

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules are complied with: All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On an identified date in September 2015, the inspector observed the garbage chute door on an identified floor to be unlocked and accessible to residents. Signage on the door stated that "Door must be kept closed at all times ".

Interviews with PSW #124 and Director of Care(DOC) revealed that the door to the garbage chute room was unlocked and it should be kept closed and locked at all times. [s. 9. (1) 2.]

2. On an identified date in September 2015, the inspector observed the garbage room door on an identified floor to be unlocked. Inspector opened the door and observed a garbage chute device in the room.

Interview with registered staff #157 confirmed that the garbage room door was unlocked and should remain locked as it is a danger to the residents.

The severity of the non-compliance and the severity of the harm and risk of further harm is minimum risk/risk for potential for actual harm.

On two identified dates in September 2015, the inspectors observed the garbage chute door on an identified floor to be unlocked and accessible to residents. The home did not ensure that doors were kept closed and locked when they are not being supervised by staff.

The scope of the non-compliance is isolated to an identified floor.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, O.Reg. 79/10., s.9 (1). A Compliance Order (CO) was previously issued for O.Reg. 79/10.,s. 9 (1) during a Resident Quality Inspection on January 5, 2015, under Inspection #2014_378116_0014. [s. 9. (1) 2.]

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 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (3) The licensee shall ensure that a sufficient supply of housekeeping equipment and cleaning supplies is readily available to all staff at the home. O. Reg. 79/10, s. 87 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including,

i. resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
ii. common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

During the course of the inspection from September 15 to October 8, 2015, the following housekeeping issues were observed:

A) Shower rooms – the tub on an identified floor was noted to be unclean. There was a heavy build up of mold on the bottom end of the shower curtain in four identified shower rooms. There was an unclean spade and unclean toilet brush located inside the shower stall in an identified shower room. Interview with PSW #171 and PSW #152 reported that the shower curtains had not been cleaned or changed since the new building opened.

B) Floor surfaces - An identified dining room, nursing station and tv lounge was observed to have discoloured (black) floors. Dried food spills were identified in the dining room. Sticky and build up matter was observed in an identified room. The elevator floors were noted to be unclean with a heavy buildup. The environmental staff reported that there is no schedule for buffing the floors and the buffing was last completed in March 2015.

C) Wall surfaces – Visibly stained area was noted on the corridor wall outside an identified room. The Director of Support Services confirmed that the expectation of staff is that if they see dirty walls, that they are cleaned as needed. Interview with the housekeeping staff and with the maintenance staff noted discrepancy on who is responsible for cleaning the walls in the corridor.

D) Baseboards – Heavy build up of dirt around the baseboards on an identified floor lounge. Interview with the housekeeping staff and with the maintenance staff noted discrepancy on who is responsible for cleaning the baseboards.

E) Servery – The warmer on an identified floor had drip marks down one side of the lower edge of the warmer. There were two broken knobs on the warmer in an identified floor servery, one of the knobs was observed underneath the floor of the warmer. The microwaves on two identified floor servery were dirty with food splatter. There was dried food splattered on the wall near the warmer on two identified floors. The coffee machine and the juice machine on an identified floor servery were observed with fresh spills at

10:49 a.m, and observed to be in the same manner at 1:50 p.m on an identified date in October 2015. There was a heavy build up of dirt on floor near an identified floor fridge. The underside of the warmer on two identified floors had accumulated matter. Heavy dust build up was noted in the corner where the carts are stored in an identified floor servery. Observed dead cockroach in corner where the carts are stored.

Interviews with three housekeeping staff and with the Director of Support Services revealed that the home does not have an established procedure or schedule for addressing when the shower rooms, walls and baseboards are to be cleaned, by whom and how. No deep cleaning schedule had been developed and housekeepers who were interviewed stated that it was up to each housekeeper what areas would be cleaned.

Interview with the Director of Support Services confirmed that housekeeping is an issue in the home, and that staffing, resources and equipment are a problem in the housekeeping and maintenance department. Housekeeping staff identified that due to staffing shortages on the weekend , there are two staff to cover the cleaning in the home, the weekend staff would only empty garbage in residents' rooms and no cleaning is completed.

A tour of the home was conducted on an identified date in October 2015, with the Administrator, environmental staff lead # 142, Director of Support Services and Responsive Management consultant who confirmed the housekeeping issues identified.

The Director of Support Services reported that previously there was an extra person in the housekeeping department whose job was to do the heavy cleaning, such as pulling out the fridge and cleaning behind and cleaning the floors, but now they have to consider bringing in a part time person to assist with the housekeeping issues. [s. 87. (2) (a)]

2. The licensee has failed to ensure that as part of the organized program of housekeeping, procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

On an identified date in September 2015, the inspector observed resident #014 and #015 wheelchairs to be visibly soiled and resident #016 rollator to be visibly soiled.

The inspector observed the three identified residents' wheelchairs and rollator on two identified dates , on which dates the wheelchairs and rollator continued to be in the same manner and visibly soiled.

Staff interviews revealed that the wheelchairs are cleaned by the night staff, and the home's process is to take the wheelchairs to the shower room for a steam cleaning. Staff interviews reported that the residents' wheelchairs were not cleaned by the night staff for the past six months.

The inspector observed in an identified floor tub room, a cupboard labelled "wheelchair cleaning supplies", but did not observe any supplies or disinfectant in the cupboard to clean the wheelchairs.

Interview with the DOC confirmed the staff are not following the home's procedure for wheelchair cleaning and a schedule will be developed to address this issue. [s. 87. (2) (b)]

3. The licensee has failed to ensure that a sufficient supply of housekeeping equipment and cleaning supplies are readily available to all staff at the home.

On an identified date in October 2015, the inspector observed the carpets on an identified floor east and west side resident lounge area near the unit entrance to be visibly dirty and heavily soiled. Observations conducted by the Director of Support Services on an identified date in October 2015, confirmed that the carpets were visibly dirty and soiled. During an interview with the Director of Support Services and environmental service lead #142, the Director of Support Services revealed that the home has not had any commercial vaccums since April 2015. The Director of Support Services revealed that he/she had brought in his/her own vaccum for the staff to use, and a request was made to purchase two vaccums to the management company.

The severity of the non-compliance and the severity of the harm and risk of further harm is minimum risk/risk for potential for actual harm.

During the course of the inspection from September 15 to October 8, 2015, multiple housekeeping issues were observed. The home confirmed that housekeeping is an issue in the home.

The scope of the non-compliance is a pattern in the home. [s. 87. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (1) As part of organized programs of housekeeping and maintenance services under clauses 15 (1) (a) and (c) of the Act, every licensee of a long-term care home shall ensure that an organized preventive pest control program using the services of a licensed pest controller is in place at the home, including records indicating the dates of visits and actions taken. O. Reg. 79/10, s. 88 (1).

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 :

1. As part of an organized program of housekeeping and maintenance services under clauses 15(1) (a) and (c) of the Act, the licensee did not ensure that an organized preventative pest control program was in place and that immediate action was taken to deal with pests.

An infestation of cockroaches was noted throughout the home during the inspection period from September 15 – October 8, 2015. During an interview with the Environmental Services lead #142 and the Administrator, they reported that the breeding ground for the cockroaches was determined to be from an identified resident's room. A tour of the home was conducted on two identified dates in October 2015 and multiple cockroaches were noted in residents' rooms, residents' washrooms and an identified floor kitchen servery. The housekeeping was not satisfactory throughout the home, with noted housekeeping issues in the servery, resident's room, resident shower room and common areas.

The preventative component of the licensee's pest control program appeared to weigh heavily on the services of the licensed pest controller and not on maintenance or housekeeping issues. Pest control records were maintained by the licensee and reviewed for service visits from January – September 2015. During the visits actions

were documented, however the actions taken did not appear to be successful in controlling the cockroaches and the licensee did not attempt to take other immediate measures. Interviews with the kitchen staff revealed that the staff observed cockroach sightings in the kitchen servery on a daily basis, from the creases of the heating warmers in the servery, in the servery fridge on an identified floor, near the water drains in the main kitchen, and anywhere where food is present. Kitchen staff identified that this is an ongoing issue in the dietary department.

Interviews with personal support workers and registered staff reported that the cockroach issue in the home is a long standing ongoing issue. Staff members reported seeing active roaches in the residents' room, washroom and dining room during meal services. Visiting family members reported to the inspector multiple sightings of roaches in the home and in an identified resident's room.

Interviews with the Administrator and Environmental Service lead #142 revealed that the home will now increase the pest controller visits and will look into further housekeeping methods of creating a schedule for deep cleaning . An integrated and organized preventative pest management program was not apparent (involving maintenance, housekeeping and pest control treatment methods) to deal with the pest issues in the home. [s. 88. (1)]

2. The licensee has failed to ensure that immediate action was taken to deal with pests.

Review of the Abell Pest Control invoices in the home's binder titled "Pest Control" indicated from January to September 2015 that the home is using the pest services three to six times a month.

Interview with environmental services lead revealed that the home has had cockroach infestations since 2010. The environmental services lead also revealed that there was an incidence where cockroaches were found under an identified resident's furniture. The home does not have a process to verify the resident's furniture before they are brought into the home.

Interview with the environmental services lead revealed that he/she vacuumed the resident's furniture after he/she found the cockroaches. The home does not have a log to document when the deep clean was completed in the home's area.

Review of the Abell Pest Control invoices and the forms titled "Ina Grafton Gage Home,

Pest Control Management" dated 2015 and interview with the environmental services lead confirmed that he/she did not find the date when the pest control company came to an identified resident's room after he/she found cockroaches in the resident's bathroom and under the resident's chair. [s. 88. (2)]

3. Interview with PSW #110 revealed he/she killed a cockroach in the servery area on an identified floor and discarded the insect into the garbage during on an identified date in September 2015. The PSW revealed that he/she did not inform the home's staff or write it in the maintenance book.

Review of the home's policy index I.D: D-05-25 titled "Safety and infection control, Pest Control" revised August 29, 2014, indicated that it is the responsibility of each employee to be observant and to accurately report and record each pest sighting. Staff members who sight a pest are required to complete the form, specifically noting date, time of sighting, what was sighted and where it was sighted.

Interview with the Director of Support Services revealed that the above home's policy has not been implemented at the present time.

Interview with the Administrator confirm that the employee should have immediately record the pest sighting and inform the maintenance staff.

The severity of the non-compliance and the severity of the harm and risk of further harm is minimum risk/risk for potential for actual harm.

An infestation of cockroaches were noted throughout the home during the inspection period from September 15 – October 8, 2015. The preventative component of the licensee's pest control program appeared to weigh heavily on the services of the licensed pest controller and not on maintenance or housekeeping issues. There are ongoing housekeeping and maintenance issues in the home. The home did not have an integrated and organized preventative pest management program to deal with the pest issues in the home.

The scope of the non-compliance is a pattern in the home. [s. 88. (2)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On an identified date in September 2015, PSW #140 and PSW #169 were present inside resident #017's washroom to assist the resident to the toilet, when the resident observed cockroaches on the floor and wall.

Interview with resident #017 revealed that while in the washroom, the PSW told the resident that the roaches will crawl into his/her ears and nose, and the resident reported

he/she became very fearful and did not sleep that night. The resident stated that one of the PSW spoke to him/her in a teasing way and it made him/her feel scared and upset. The resident stated that he/she reported his/her concerns to the unit manager. Interview with the manger of clinical informatics revealed that the resident did report his/her concerns to her and reported that the resident states he/she was fearful by the PSW's comment.

Interview with PSW #140, who provided care to resident #017 on an identified date in September 2015, revealed that he/she did tell the resident that he/she saw roaches on the wall, but states he/she did not tell the resident it wall crawl in his/her ears. Interview with DOC confirmed that the resident was upset about the situation and that the resident was not treated with courtesy and respect. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every residents right not to be neglected by the licensee or staff are fully respected and promoted.

Record review of Critical Incident, the home's Client Service Response form and interview with resident #026 revealed that one day in June 2015, the resident was not feeling well and vomited in his/her bathroom. The resident called for assistance using the call bell and a staff member attended the room inquiring if the resident was okay. Resident reported to the staff that he/she wasn't feeling well and had vomited. The staff member left the room and did not return, leaving the resident to clean up his/her emesis. Interview with resident #026 revealed that he/she was upset that staff did not attend to him/her when he/she was feeling unwell and had vomited.

Record review of the home's investigation notes did not identify the staff responsible for attending the resident's room and not returning to assist him/her, after he/she called for assistance using the call bell on an identified day in June 2015.

Interview with RPN #113 revealed that resident #026 reported that he/she wasn't feeling well in June 2015 and vomited in his/her room. Resident did not report that he/she used his/her call bell to call for assistance from staff. RPN #113 reported that the DOC at that time, who no longer works in the home, received a concern from the resident about the incident two weeks later, and the DOC informed him/her that a staff attended the resident's room in response to the call bell. The staff left the resident's room and did not return, leaving the resident to clean up his/her own emesis. The resident was unable to remember who the staff was that attended her room initially then did not return to assist him/her.

Interview with RPN #113 and the Administrator confirmed that the resident's right not to be neglected was not fully respected and promoted. [s. 3. (1) 3.]

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

On an identified date in September 2015, the door to the bathing centre located on an identified floor unit was observed to be open, unlocked and unsupervised. Inspector #116 and the staffing clerk #105 entered the bathing centre and observed the door to the washroom to be open and resident # 020 seated on the toilet unattended and unsupervised. Resident #020's, lower body was uncovered and exposed.

Interviews with PSW #104, PSW #110, registered staff #103 and the DOC confirmed that the resident was not afforded privacy in caring for his/her personal needs. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, every resident has the right not to be neglected by the licensee or staff and to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs is fully respected and promoted, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for

its residents.

On an identified date in September 2015, the door to the bathing centre on an identified floor unit was observed to be open, unlocked and unsupervised. The inspector and the staffing clerk #105 entered the bathing centre and observed the door to the washroom to be open and resident #020 seated on the toilet unattended and unsupervised. The shower room adjacent to the washroom was in use and the door was closed. Approximately ten minutes later, PSW #104 returned to attend to the resident.

Cleaning solutions and equipment are stored within the bathing centre.

Interviews with PSW #104, PSW #110 and registered staff #103 confirmed that the bathing centre door is to be closed and locked at all times for the safety of the residents. Further interviews held with the Administrator, Director of Care and Environmental Service lead confirmed that the doors should be locked at all times. [s. 5.]

2. On an identified date in October 2015, the following issues were observed:

A) Flooring – Shower rooms on two identified floors had cracked and loose flooring materials within the shower surround.

B) Walls – The wall in the tub room on an identified floor above the shower head was cracked, bubbled and peeling off approximately one foot in length. There are several cracked wall tiles in three identified shower room stall, allowing water to seep underneath. There was peeling drywall in the bottom of the shower stall on an identified floor, exposing the metal joist of wall. There was a hole in the wall located in servery on an identified floor.

Interview with PSW #171 revealed that he/she had previously notified the DOC and environmental service lead about the disrepair. Interview with the Environmental service lead #142 revealed that he/she was not aware of the damaged walls and flooring in the shower and tub rooms, as the staff did not notify or documented the disrepair in the maintenance log. The maintenance log was reviewed and there were no entries that staff (housekeeping, personal support workers and nursing) had documented any issues with the shower and tub room flooring and walls. A tour of the home was conducted on an identified date in October 2015, with the Administrator , environmental service lead #142 and Responsive Management consultant who confirmed that the above areas are in unsafe condition and disrepair. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 has failed to ensure that there was a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident.

Record review of the progress notes on an identified date in April 2015, indicated resident #013 had an alteration in skin integrity to an identified area. Record review of the written plan of care on an identified date in March 2015, did not indicate the above

resident had an alteration in skin integrity.

Interview with registered staff #146 revealed that resident #013 sustained an alteration in skin integrity on the identified area in April 2015, but did not indicate when it was healed.

Interview with the DOC revealed resident #013's written plan of care and the treatment administration record (TAR) did not indicate that the resident had an alteration in skin integrity on the identified area and confirmed that the above records did not set out clear direction to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident, the resident's substitute decision maker, if any, and any other persons designated by the resident or substitute decision maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On an identified date in February 2015, resident #029 was sent to hospital as heshe was not eating or drinking for several days. The resident was admitted to the hospital.

Interview with resident #029's substitute decision maker (SDM) revealed that on an identified date in February 2015, he/she received a phone call from the paramedics to inform that the resident was sent to hospital. The SDM stated that he/she was not informed by the home prior to sending the resident to hospital that the resident's condition had changed.

Interview with registered staff #163, who worked on the identified date and transferred the resident to the hospital, confirmed that he/she did not immediately call the SDM to notify of the change of status and that the resident was transferred to hospital. Interview with the DOC and registered #163 confirmed that the home's expectation is to notify the SDM immediately when there is change of status to the resident. [s. 6. (5)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of the written plan of care and continence profile worksheet for resident #021 documents that the resident wears a brief of an identified size.

On an identified date in September 2015, the resident was observed to be wearing a larger sized brief. Interview with the assigned PSW #119 confirmed having knowledge of

the resident's required brief size however, he/she applies a larger sized brief as he/she feels it fits the resident better and is more suitable due to the frequency of bowel movements of the resident. The PSW further confirmed that he/she did not bring forward the concerns of refitting for the resident to the appropriate designate.

Interviews held with the registered staff #113 and the DOC confirmed that resident #021 was not provided with the specified care regarding continence care products. [s. 6. (7)]

4. The written plan of care for resident #017 dated June 2015, indicated that the resident requires two staff to transfer via lift.

On an identified date in July 2015, PSW # 140 transferred the resident manually from bed to wheelchair without the use of a lift and without a second person assisting. The resident sustained a laceration to an identified area.

Interview with PSW #140 who was assigned to resident #017 on the identified date, registered staff #127 who also worked that shift, and the DOC confirmed that PSW #140 transferred the resident without a second person assisting and without the use of a lift. The DOC confirmed that the care set out in the plan of care was not provided to resident #017. [s. 6. (7)]

5. Review of the written plan of care for resident #029 dated October 2014, states resident will maintain adequate hydration with fluids greater than 1100ml a day. Resident #029 was assessed by the dietitian as high nutritional risk.

On an identified date in February 2015, resident was sent to hospital as he/she was not eating or drinking for several days. The resident was admitted to the hospital. Record review of resident #029's food and fluid total intake consumed from an identified period in February 2015, revealed seven days that the fluid intake was less than 1100 ml.

Record review of resident #029's meal consumption from an identified period in February 2015, revealed the resident refused to eat his/her meals on five identified dates.

Interview with PSW #164 and registered staff #163 confirmed that the resident was not eating or drinking. Registered staff #163 reported that upon assessing the resident on the identified date in February 2015, he/she was surprised to see that the resident's condition had changed as the resident's condition was not like this when he/she worked a few days prior. Registered staff #163 stated that he/she was told by the full time PSW that the

resident was not eating or drinking for several days. Registered staff #163 assessed the resident and sent the resident to the hospital.

Interview with the DOC confirmed that the resident did not maintain adequate hydration with fluids greater that 1100ml a day as per the resident's plan of care. [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 that 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, that the resident, the resident's substitute decision maker, or any other person designated by the resident or substitute decision maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's policy titled "Monitoring Fluid Intake" dated February 24, 2015, directs the registered staff to monitor the residents fluid intake, and if the fluid intake of the resident is consecutively low two days in a row, the registered staff must assess the resident, review the chart, and alert the incoming registered staff. The incoming registered staff will initiate food study monitoring, inform the SDM, update attending physician and refer to the registered dietitian or Nurse Practitioner to rule out dehydration.

On an identified date in February 2015, resident #029 was sent to hospital as he/she was not eating or drinking for several days. The resident was admitted to the hospital.

Interview with PSW #164, registered staff #118, registered staff #163 and with the DOC confirmed that a 3 day food and fluid intake monitoring was not completed during an identified period in February 2015, when the resident was not eating or drinking. Interview with the Registered Dietitian (RD) confirmed that he/she was not notified by the registered staff that the resident was not eating or drinking. Interview with the DOC confirmed that the staff did not follow the home's policy related to monitoring fluid intake. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #8: 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 has failed to ensure that the home, furnishings, and equipment are kept clean and sanitary.

On an identified date in September 2015 and October 2015, the inspector observed the bath tub on an identified floor to be dusty and dirty.

Interview with PSW #138 on an identified date in September 2015, confirmed the tub was dirty.

Interview with the Director of Support Services revealed the bath tub was dirty and he/she cannot identify when the tub room was cleaned since the sheet titled "Common Areas Cleaning sign sheet" only began to be signed by the staff on October 1, 2015.

Review of the Common Areas Cleaning sign sheet indicated that the tub and shower rooms were cleaned on October 1, 2015, on an identified floor.

Interview with housekeeping aide #147 revealed that the tub room was cleaned on October 1, 2015, but he/she did not clean the bath tub.

Interview with the Director of Support Services confirmed the bath tub is to be kept clean and sanitary and the bath should have been cleaned on October 1, 2015. [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #9: 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. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Record review and interviews held with the Director of Care and Administrator regarding the annual evaluation of the staffing plan provided conflicting information. The written record of the annual evaluation provided to the inspector did not support that a 2014 annual evaluation of the staffing plan was conducted as specified in the regulations. [s. 31. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written record cord relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The written plan of care for resident #018 dated April 2015, indicated that the resident requires two staff to transfer via mechanical lift.

On an identified date in April 2015, PSW #150 and PSW #131 transferred the resident from bed to wheelchair via mechanical lift when the PSW noticed blood on an identified area of the resident's body. The resident was assessed by registered staff #132 and was sent to the hospital. The resident sustained an injury to the identified area.

Interviews with PSW #150 and PSW #131 revealed that during the transfers the resident reported that his/her identified area of the body hit the mechanical lift after they noticed the bleeding to the identified area.

Interview with the Physiotherapist, registered staff #132, PSW #150, PSW #131 and the DOC confirmed that resident #018 sustained an injury during the transfer with a mechanical lift. The DOC confirmed that the staff did not use safe transferring techniques when assisting resident #018 with transfers. [s. 36.]

2. The written plan of care for resident #017 dated June 2015, indicated that the resident requires two staff to transfer via lift.

On an identified date in July 2015, PSW #140 transferred the resident manually from bed to wheelchair without the use of a lift and without a second person assisting. The resident sustained an injury to an identified area of the body.

Interview with PSW #140 who was assigned to resident #017 on the identified date, registered staff #127 who also worked that shift, and the DOC confirmed that PSW #140 transferred the resident without a second person assisting and without the use of a lift. The DOC confirmed that the staff did not use safe transferring techniques when assisting resident #017 with transfers. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the interdisciplinary team that co-ordinates and implements the Infection Prevention and Control program meet at least quarterly.

Review of the home's Infection Prevention and Control program and interview with the DOC confirmed that the interdisciplinary team co-ordinates and implements the Infection Prevention and Control program did not meet at least quarterly in 2014. [s. 229. (2) (b)]

2. The licensee has failed to ensure that Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Review of the home's Infection Prevention and Control program and interview with the DOC confirmed that the above program was not evaluated and updated in 2014. [s. 229. (2) (d)]

3. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program

On an identified date in September 2015, the inspector observed an unlabelled toothbrush in a kidney basin, stored in the in the bathroom that is shared by two residents.

Interview with registered staff #157 confirmed that resident's personal items should be labelled, limiting the potential infection risk to residents. [s. 229. (4)]

4. On an identified date in September 2015, the inspector observed four unlabelled toothbrushes and kidney basins to be located in resident #031's bin, stored in the bathroom that is shared by two residents.

Interview with registered staff #157 and PSW #171 revealed that resident #031 is currently not in the home and had been discharged from the home six months prior. PSW #171 revealed that the unlabelled toothbrush belongs to resident #032. Registered staff #157 and PSW #171 confirmed that resident #032's personal items should not be stored in another resident's bin which thereby potentially exposing resident to infection. [s. 229. (4)]

5. On an identified date in October 2015 , during an observation of the servery on an identified floor, the inspector observed a large juice spill on the bottom of the snack cart at 10:50 a.m and observed the snack cart in the same manner at 1:50 p.m. The juice spill was not cleaned. The inspector observed the 2:00 p.m snacks placed on the top of the snack cart. Interview with the dietary aide #148 confirmed that snack cart was kept in an unclean manner. [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 to ensure that the interdisciplinary team co- ordinates and implements the program meets at least quarterly, that the program is evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, and to ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

WN #12: 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 has failed to ensure that 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 is based to the Director : Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

On an identified date in April 2015, PSW #150 and PSW #131 transferred resident #018 from bed to wheelchair via mechanical lift when the PSW's noticed blood on the an identified area of the resident's body. The resident was assessed by registered staff #132 and was sent to the hospital. The resident sustained an injury to the identified area.

Review of the Critical Incident record submitted to the Ministry of Health and Long Term Care on an identified date in May 2015, indicated that the incident occurred in April 2015. Interview with the DOC confirmed that the home did not immediately report the suspicion of improper or incompetent care of a resident that resulted in harm to the resident to the Director. [s. 24. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to time of day and keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

On an identified date in September 2015, the inspector observed resident #019 sitting in his/her wheelchair in the TV lounge on an identified floor with his/her shirt placed on backwards, and the shirt was buttoned up and tight around the resident's neck. The inspector observed the resident pulling at his/her neck collar as the shirt appeared tight around the neck. The inspector and registered staff #135 approached the resident. The registered staff proceeded to unbutton the neck collar. The registered staff reported to the inspector that the resident's shirt is placed inappropriately and the resident was appropriately dressed before he/she came into the dining room for lunch.

Interview with PSW #141 who was assigned to the resident on the identified date, reported to the inspector that the resident would frequently undress, and was undressing in the dining room during lunch, when the PSW decided to take the shirt and place it backwards to prevent the resident from undressing.

Interview with PSW #141, registered staff #135, and the DOC confirmed that the resident was not dressed appropriately on the identified date in September 2015, and will identify interventions to address this issue. [s. 40.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was 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.

Record review of the progress notes in April 2015, indicated that resident #013 had an alteration to skin integrity on an identified part of the body.

Interview with the registered dietitian (RD) revealed that he/she received a referral for the resident's skin in August 2015, and the comment area did not indicate the specific area or the reason for the skin referral. At that time, resident #013 did not have an alteration to skin integrity.

Interviews with registered staff #146 and DOC confirmed resident #013 was not referred or seen by the RD for the alteration in skin integrity in April 2015. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcer, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of the progress notes in April 2015, indicated resident #013 had an alteration to skin integrity on an identified part of the body.

Review of the progress notes, the risk incident management records (RIM), and the assessment under Point Click Care task does not indicate that the resident's alteration in skin was reassessed at least weekly.

Interview and record review with registered staff #146 and DOC revealed that the resident's alteration in skin integrity on an identified part of the body does not indicate when the wound was healed .

Interview with registered staff #146 and DOC confirmed resident #013's skin was not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

3. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of the progress notes indicated that resident #010 sustained an alteration in skin integrity on an identified area and was cleaned with normal saline and a dry dressing was applied on an identified date in September 2015. Review of the progress notes written by the physician on an identified date in September 2015, for resident #010 indicated there was a very minor alteration in skin on his/her identified area which has done well.

Interview with registered staff #103 revealed that the progress notes did not indicate when resident #010's alteration in skin on the identified area was healed and the weekly assessment was not completed.

Interview with the manager of clinical informatics confirmed the resident's skin was not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review of an identified date, Residents' Council meeting minutes included concerns raised by the president regarding cockroaches in his/her bathroom, squeaky beds, unclean floors and smelly rooms.

Interview with the Residents' Council Chair revealed that the home did not respond to his/her concerns raised at the identified date Residents' Council meeting. Interview with the Residents' Council Assistant revealed that he/she attended the identified month Residents' Council meeting, and was aware of the above mentioned concerns raised, but did complete a Residents' Council Concern form or notify the Administrator. The home has not yet responded to the concerns raised. Interview with the Administrator confirmed that he/she was not notified about the concerns raised at the identified date, Residents' Council meeting, and the home did not respond in writing within 10 days of receiving advice related to concerns. [s. 57. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has, and that the staff of the home complies with a cleaning schedule for all equipment.

On an identified date in October 2015 , the inspector observed a greasy spill on the front area of the stove top/range oven in the basement of the kitchen area for the food production.

Interview with the Director of Support Services revealed that there was a greasy spill on the front area of the stove top/range oven and that the oven was not used on an identified date in October 2015.

Review of the form titled "Facilities and equipment cleaning schedule, Department: Dietary" indicated to clean spills immediately on the stove top/range oven.

Interviews with food service workers #148 and #149 had conflicting schedule for cleaning the stove/oven; one staff revealed that it is cleaned when it is dirty and the other revealed that it is cleaned on an identified day of the week.

Interview with the Director of Support Services revealed the home did not have a signed form for the cleaning of the stove/oven and a new signed form was implemented but was not signed yet.

During the interview, the Director of Support Services could not confirm that the stove/oven was cleaned prior to, and the cook cleaning schedule with signature for all equipment in the food production needed to be implemented and signed by the employee. [s. 72. (7) (b)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

Record review of Residents' Council minutes did not include a review of the home's meal and snack times by Residents' council.

Interview with the Residents' Council chair, Residents' Council co-chair and Director of Support Services confirmed that the home's meal and snack times were not reviewed by the Residents' Council in 2014. [s. 73. (1) 2.]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the public inspection reports from the past two years for the long-term care home were posted in the home.

On an identified date in September 2015, the inspector observed the following reports were not posted in the home:

2014_195166_0010
2014_357101_0016
2013_195166_0027

The absence of the reports was confirmed by the Administrator, and the reports were later posted. [s. 79. (3) (k)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, at least once in every year, a survey was taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

Record review of the home's Resident Satisfaction Survey for 2014 and interview with the DOC and administrator revealed that there were no questions included in the resident satisfaction survey conducted in 2014, pertaining to programs provided in the home such as: skin and wound care, falls prevention, physiotherapy and occupational therapy. [s. 85. (1)]

2. The licensee has failed to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Record review of the Residents' Council meeting minutes and interview with the Residents' Council Chair confirmed that the home did not seek the advice of the Residents' Council in developing and carrying out the 2014 satisfaction survey. Interview with the Residents' Council assistant reported that he/she does not recall if the home seek the advice of the Residents' Council related to the satisfaction survey. [s. 85. (3)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area of medication cart that is used exclusively for drugs and drug related supplies and that is secure and locked.

On an identified date in September 2015, during observations of the medication cart, the inspector observed non drug-related items being stored in the double locked narcotics bins. These item included an envelope with a cheque for resident #022 . Staff interview with the registered staff #135 and DOC confirmed that the medication cart is used exclusively for drugs and drug related supplies. [s. 129. (1) (a)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's drug destruction and disposal policy include that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substances that is available for administration to a resident, until the destruction and disposal occurs.

The home's narcotic drug destruction and disposal policy F-35, revised September 18, 2014, directs the registered staff that all controlled substances which are to be destroyed are stored in a double locked cabinet or narcotic box until the pharmacist and one member of the registered staff performs drug destruction and disposal occurs.

On an identified date in September 2015, the inspector observed a discontinued narcotic card with three identified pills intact in the package for resident #023 in the double locked narcotic box inside the medication cart on an identified floor that was not separate from controlled substance available for the resident. The discontinued narcotic was also observed in the current narcotic bin.

Interviews with the DOC, ADOC, and Registered staff #135 confirmed that the expired medications was not stored in a double locked storage area, separate from any controlled substances that is available for administration to a resident, until the destruction and disposal occurs as per process. The home's expectation is the discontinued narcotic medication is stored in the locked narcotic box in DOC office. [s. 136. (2) 2.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene;
(b) modes of infection transmission;
(c) cleaning and disinfection practice; and
(d) use of personal protective equipment.

Review of the home's training records did not indicate that staff received the above training and retraining in infection prevention and control as required.

Interview with the administrator confirmed that not all staff received training and retraining in infection prevention and control in 2014. [s. 219. (4)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, that skin and wound care training was provided to all staff who provide direct care to residents.

Review of the home's training indicated that nine staff attended the wound in-service in July 2014.

Interview with the administrator confirmed that not all staff who provided direct care to residents received training in skin and wound care in 2014. [s. 221. (1) 2.]

Issued on this 29th day of February, 2016

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

Original report signed by the inspector.

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) :	NICOLE RANGER (189), JOELLE TAILLEFER (211), SARAN DANIEL-DODD (116), THERESA BERDOE-YOUNG (596)
Inspection No. / No de l'inspection :	2015_405189_0017
Log No. / Registre no:	024207-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 22, 2016
Licensee / Titulaire de permis :	INA GRAFTON GAGE HOME OF TORONTO 40 Bell Estate Road, SCARBOROUGH, ON, M1L-0E2
LTC Home / Foyer de SLD :	INA GRAFTON GAGE HOME 40 Bell Estate Road, SCARBOROUGH, ON, M1L-0E2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rob Bissonnette

To INA GRAFTON GAGE HOME OF TORONTO, 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)

Linked to Existing Order / Lien vers ordre existant: 2014_378116_0014, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

Develop, submit and implement a plan to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Plan to be submitted via email to nicole.ranger@ontario.ca by March 14, 2016

Grounds / Motifs :

1. The licensee has failed to ensure that the following rules are complied with: All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On an identified date in September 2015, the inspector observed the garbage chute door on an identified floor to be unlocked and accessible to residents. Signage on the door stated that "Door must be kept closed at all times ".

Interviews with PSW #124 and Director of Care(DOC) revealed that the door to the garbage chute room was unlocked and it should be kept closed and locked at all times. (189)

2. On an identified date in September 2015, the inspector observed the garbage room door on an identified floor to be unlocked. Inspector opened the door and observed a garbage chute device in the room.

Interview with registered staff #157 confirmed that the garbage room door was unlocked and should remain locked as it is a danger to the residents.

The severity of the non-compliance and the severity of the harm and risk of further harm is minimum risk/risk for potential for actual harm.

On two identified dates in September 2015, the inspectors observed the garbage chute door on an identified floor to be unlocked and accessible to residents. The home did not ensure that doors were kept closed and locked when they are not being supervised by staff.

The scope of the non-compliance is isolated to an identified floor.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, O.Reg. 79/10., s.9 (1). A Compliance Order (CO) was previously issued for O.Reg. 79/10.,s. 9 (1) during a Resident Quality Inspection on January 5, 2015, under Inspection #2014_378116_0014. (596)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 06, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

1. The licensee shall address/clean all of the areas/surfaces identified in the grounds below by April 30, 2016:

2. Clean all resident rooms, dining rooms, common areas and tub rooms on a daily basis, as identified in the home's housekeeping policies and procedures.

3. Develop, submit and implement a plan that details how the housekeeping tasks and routines to maintain the home will be sustained over the long term. The plan, at a minimum shall include a routine auditing program to ensure adherence to the home's written housekeeping policies and procedures, including any/all required documentation, and to ensure compliance with the Long-Term Care Homes Act and Regulation.

Plan to be submitted to nicole.ranger@ontario.ca by March 14, 2016

Grounds / Motifs :

1. 1. The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including,
i. resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
ii. common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

During the course of the inspection from September 15 to October 8, 2015, the following housekeeping issues were observed:

A) Shower rooms – the tub on an identified floor was noted to be unclean. There was a heavy build up of mold on the bottom end of the shower curtain in four identified shower rooms. There was an unclean spade and unclean toilet brush located inside the shower stall in an identified shower room. Interview with PSW #171 and PSW #152 reported that the shower curtains had not been cleaned or changed since the new building opened.

B) Floor surfaces - An identified dining room, nursing station and tv lounge was observed to have discoloured (black) floors. Dried food spills were identified in the dining room. Sticky and build up matter was observed in an identified room. The elevator floors were noted to be unclean with a heavy buildup. The environmental staff reported that there is no schedule for buffing the floors and the buffing was last completed in March 2015.

C) Wall surfaces – Visibly stained area was noted on the corridor wall outside an identified room. The Director of Support Services confirmed that the expectation of staff is that if they see dirty walls, that they are cleaned as needed. Interview with the housekeeping staff and with the maintenance staff noted discrepancy on who is responsible for cleaning the walls in the corridor.

D) Baseboards – Heavy build up of dirt around the baseboards on an identified floor lounge. Interview with the housekeeping staff and with the maintenance staff noted discrepancy on who is responsible for cleaning the baseboards.

E) Servery – The warmer on an identified floor had drip marks down one side of the lower edge of the warmer. There were two broken knobs on the warmer in an identified floor servery, one of the knobs was observed underneath the floor of the warmer. The microwaves on two identified floor servery were dirty with food splatter. There was dried food splattered on the wall near the warmer on two identified floors. The coffee machine and the juice machine on an identified floor servery were observed with fresh spills at 10:49 a.m, and observed to be in the same manner at 1:50 p.m on an identified date in October 2015. There was a heavy build up of dirt on floor near an identified floor fridge. The underside of the warmer on two identified floors had accumulated matter. Heavy dust build up was noted in the corner where the carts are stored in an identified floor servery. Observed dead cockroach in corner where the carts are stored.

Interviews with three housekeeping staff and with the Director of Support Services revealed that the home does not have an established procedure or schedule for addressing when the shower rooms, walls and baseboards are to be cleaned, by whom and how. No deep cleaning schedule had been developed and housekeepers who were interviewed stated that it was up to each housekeeper what areas would be cleaned.

Interview with the Director of Support Services confirmed that housekeeping is an issue in the home, and that staffing, resources and equipment are a problem in the housekeeping and maintenance department. Housekeeping staff identified that due to staffing shortages on the weekend , there are two staff to cover the cleaning in the home, the weekend staff would only empty garbage in residents' rooms and no cleaning is completed.

A tour of the home was conducted on an identified date in October 2015, with

the Administrator, environmental staff lead # 142, Director of Support Services and Responsive Management consultant who confirmed the housekeeping issues identified.

The Director of Support Services reported that previously there was an extra person in the housekeeping department whose job was to do the heavy cleaning, such as pulling out the fridge and cleaning behind and cleaning the floors, but now they have to consider bringing in a part time person to assist with the housekeeping issues.

The severity of the non-compliance and the severity of the harm and risk of further harm is minimum risk/risk for potential for actual harm.

During the course of the inspection from September 15 to October 8, 2015, multiple housekeeping issues were observed. The home confirmed that housekeeping is an issue in the home.

The scope of the non-compliance is a pattern in the home. (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 06, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 88. (1) As part of organized programs of housekeeping and maintenance services under clauses 15 (1) (a) and (c) of the Act, every licensee of a long-term care home shall ensure that an organized preventive pest control program using the services of a licensed pest controller is in place at the home, including records indicating the dates of visits and actions taken. O. Reg. 79/10, s. 88 (1).

Order / Ordre :

Develop, submit and implement a plan outlining the steps to be taken to effectively deal with the ongoing pest control issues at Ina Grafton Gage home. The plan shall include, but not limited to, an integrated and organized approach to the preventative pest management program.

The plan to be submitted to nicole.ranger@ontario.ca by March 14, 2016

Grounds / Motifs :

1. 1. As part of an organized program of housekeeping and maintenance services under clauses 15(1) (a) and (c) of the Act, the licensee did not ensure that an organized preventative pest control program was in place and that immediate action was taken to deal with pests.

An infestation of cockroaches was noted throughout the home during the inspection period from September 15 – October 8, 2015. During an interview with the Environmental Services lead #142 and the Administrator, they reported that the breeding ground for the cockroaches was determined to be from an identified resident's room. A tour of the home was conducted on two identified dates in October 2015 and multiple cockroaches were noted in residents' rooms, residents' washrooms and an identified floor kitchen servery. The housekeeping was not satisfactory throughout the home, with noted housekeeping issues in the servery, resident's room, resident shower room and common areas.

The preventative component of the licensee's pest control program appeared to

weigh heavily on the services of the licensed pest controller and not on maintenance or housekeeping issues. Pest control records were maintained by the licensee and reviewed for service visits from January – September 2015. During the visits actions were documented, however the actions taken did not appear to be successful in controlling the cockroaches and the licensee did not attempt to take other immediate measures. Interviews with the kitchen staff revealed that the staff observed cockroach sightings in the kitchen servery on a daily basis, from the creases of the heating warmers in the servery, in the servery fridge on an identified floor, near the water drains in the main kitchen, and anywhere where food is present. Kitchen staff identified that this is an ongoing issue in the dietary department.

Interviews with personal support workers and registered staff reported that the cockroach issue in the home is a long standing ongoing issue. Staff members reported seeing active roaches in the residents' room, washroom and dining room during meal services. Visiting family members reported to the inspector multiple sightings of roaches in the home and in an identified resident's room.

Interviews with the Administrator and Environmental Service lead #142 revealed that the home will now increase the pest controller visits and will look into further housekeeping methods of creating a schedule for deep cleaning. An integrated and organized preventative pest management program was not apparent (involving maintenance, housekeeping and pest control treatment methods) to deal with the pest issues in the home. [s. 88. (1)]

The severity of the non-compliance and the severity of the harm and risk of further harm is minimum risk/risk for potential for actual harm.

An infestation of cockroaches was noted throughout the home during the inspection period from September 15 – October 8, 2015. The preventative component of the licensee's pest control program appeared to weigh heavily on the services of the licensed pest controller and not on maintenance or housekeeping issues. There are ongoing housekeeping and maintenance issues in the home. The home did not have an integrated and organized preventative pest management program to deal with the pest issues in the home.

The scope of the non-compliance is a pattern in the home. (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 06, 2016

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 22nd day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NICOLE RANGER

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