



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

**Rapport d'inspection
prévus le *Loi de 2007
les foyers de soins de
longue durée***

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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**Ministère de la Santé et des Soins de
longue durée**

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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 12 & 13, 2011	2011-120-9562-12Jan173740	H-00130 Follow-up to January 12 & 13, 2010
Licensee/Titulaire		
The Regional Municipality of Peel, 10 Peel Centre Drive, Suite B, 4th Fl., Brampton, ON L6T 0E5		
Long-Term Care Home/Foyer de soins de longue durée		
Peel Manor, 525 Main Street North, Brampton, ON L6X 1N9		
Name of Inspector(s)/Nom de l'inspecteur(s)		
Bernadette Susnik, LTC Homes Inspector – Environmental Health #120		
Inspection Summary/Sommaire d'inspection		
The purpose of this visit was to conduct a follow-up inspection to previously issued non-compliance made under the Ministry of Health and Long-Term Care Homes Program Standards Manual with respect to the following unmet criteria: • M3.26 (Infection Prevention and Control) • M3.3 (Safety Systems) • O2.1 (Maintenance Services) • O3.1 (Housekeeping Services) During the course of the inspection, the above noted inspector spoke with the Administrator, Environmental Services Supervisor, housekeeping and nursing staff. During the course of the inspection, a walk-through of the building was conducted which included resident rooms, washrooms, soiled utility rooms, serveries, dining rooms and bathing rooms. Several housekeeping staff were observed during their cleaning routines, the nurse call and door access control systems were tested and maintenance documentation was reviewed. The following Inspection Protocols were used: • <i>Infection Prevention and Control</i> • <i>Accommodation Services – Housekeeping</i> • <i>Accommodation Services – Maintenance</i> • <i>Safe and Secure Home</i> ☒ Findings of Non-Compliance were found during this inspection. The following action was taken: 6 WN 6 VPC		

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: *The licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c. 8 s. 86(2).* The infection prevention and control program must include,

(b) measures to prevent the transmission of infections.

Previously issued as Unmet Criterion M3.26 under the MOHLTC Homes Program Standards Manual.

Findings:

- The Amsco Cycloflush Bed Pan Washer located in each of the soiled utility rooms are not being used by staff. Heavy amounts of dust were noted around the edges of the opening of most of the units and heavy dust noted on the drainage racks, all indicators of a lack of use. A policy was found in the nursing care manual titled "Bed Pan Flusher" which was created on July 25/05. It describes that staff are to use the Cycloflush machine, but does not indicate how often staff are to use the machine nor does it indicate how washbasins are to be washed. The machines are designed for bedpans and urinals only.
- The manufacturer's manual requires the hot steam/water cycle to reach 82°C for a minimum of 30 seconds. When the machine located in the WHW soiled utility room was tested after the steam/water cycle was completed, the temperature was noted to be approximately 60°C. No records could be provided to determine if any of the machines are routinely monitored by maintenance staff to determine if the machines are working according to manufacturer's specifications.
- Within the same nursing care manual available to staff, a mix of instructions as to when and how to clean personal care articles such as bedpans and washbasins was found. Three separate policies (LTC9-7.1, LTC9-7.17 and LTC9-7.16) were noted in the binder and none referenced using the Cycloflush machines. These policies require the staff to clean items manually and apply a disinfectant to the articles. None of the soiled utility rooms in the home had any disinfectant supplies which would indicate that they are following the procedures.

Additional Required Action:

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 with s. 86(2) in respect to ensuring that all staff use measures to prevent the transmission of infections, to be implemented voluntarily.

WN #2: The licensee failed to comply with O. Reg. 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained.

Location	Lux
Stairways	Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors	Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home	Minimum levels of 215.84 lux
Each drug cabinet	Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position	Minimum levels of 376.73 lux

Findings:

The minimum level of 215.84 lux of illumination is not met in various resident washrooms. The level of illumination in randomly selected resident washrooms was measured using the Sekonic Handi Lumi Light Meter, held at waist level in the centre of the room. Poor levels of illumination were identified in numerous identified resident washrooms. The lux readings for these rooms ranged between 25 and 190.

Additional Required Action:

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 with s.18 in respect to ensuring that the lighting requirements set out in the above table are maintained, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s.15(2)(a) & (c). Every licensee of a long-term care home shall ensure that,

- (a) the home, furnishings and equipment are kept clean and sanitary;
- (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Previously issued as unmet criteria O3.1 and O2.1 under the MOHLTC Homes Program Standards Manual.

Findings:

- Heavy accumulation of visible matter noted on the wall, door, door frame just upon entry into the service area of the servery located in the Fountainview Home area. The wall surrounding the hand sink and garbage can were also visibly dirty. The walls soiled around the dish machine in the Community Dining room servery and on the door surfaces, Walls splattered with visible matter in the 2nd floor small dining room, near table #6 and on wall with mail box. Walls soiled in the Huxley hall servery under white upper cabinets.
- Night table very dirty in one identified resident room.
- Exhaust grilles are heavily coated in dust in many resident washrooms, WHW spa, 2nd floor large servery)
- Soiled utility rooms throughout the home noted to have debris and dust on the floors, dirty walls, walls that are no longer easy to clean due to peeling paint, cabinets under the sinks are dirty and full of unused items that are also dirty/dusty.
- Water stained ceiling tiles noted in the Huxley Hall dining room
- The tub lift seats (underside) noted to have accumulated yellow residue in both the Fountainview tub room and in the Blue Jay Way tub room.
- The flooring material in and around the floor drain of the Fountainview tub room has been repaired in the past with a new section applied. The seams around this new section have split, and water squirted out from under the floor when stepped on. Similarly, in the WHW spa room, a seam has split in the shower area, allowing water to seep underneath. Flooring material was not properly installed around the drain in the BJW shower area as the floor is not attached in any way to the subfloor and can be lifted. The flooring

material in the WHW housekeeping closet is split and lifting.

- Large gaps exist between many of the glass double doors leading to the outdoors. These gaps permit the entrance of insects in the warmer months and snow and cold drafts in the winter months.

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 with s.15(2)(a) & (c) in respect to ensuring that the home, furnishings and equipment are kept clean and sanitary and the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

WN #4: *The licensee has failed to comply with the 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.

Previously issued as criterion M3.3 under the MOHLTC Homes Program Standards Manual.

Findings:

- Various areas of the building were noted to be accessible to residents where their safety is at risk. The Huxley Hall dining room servery was accessible to residents on both days of the review. The small door to the servery was left open and cleaning chemicals and the steam tables (which were on and at over 60°C) were accessible.
- The concrete sidewalk in the front of the building that is used by visitors, residents and staff has heaved upwards in two places, causing a tripping hazard. (Plans reviewed for the renovation of this area, however no start date or completion date given).
- A housekeeping cart was left in the secured unit which houses residents with dementia, for 7 minutes, unattended. A bottle of disinfectant was left hanging off the side of the cart. Residents were noted to be wandering around the cart.
- A resident was left unattended in the small dining room on the 2nd floor, with both sets of dining room doors locked. Not all of the staff who were asked to open the doors had keys to the dining room should immediate assistance be required. For a short period of time, no staff were present at the nurse's station (across from the dining area with direct line of sight into the room through glass walls). The steam table in this dining room was found to be on and steaming hot and directly accessible to the resident.

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 with s. 5 in respect to ensuring that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN#5: *The licensee has failed to comply with O. Reg. 79/10, s. 17(1)(f).* Every licensee of a long term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(f) clearly indicates when activated where the signal is coming from.

Findings:

Pagers, which are a required component of the resident-staff communication and response system for Peel Manor, are the sole source of equipment used to alert staff that a station has been activated and that also clearly indicate where the signal is coming from. The resident-staff communication and response system at Peel Manor does not have an audible component throughout the home areas because pagers have replaced that component.

- During the inspection, very few personal service workers (PSWs) were wearing their pagers. On

the 2nd floor, 7 pagers were noted to be left sitting at the nurse's station. Only one PSW on the afternoon shift was wearing her pager. The charge nurse and two additional PSWs apparently working did not have a phone/pager on their person. On the 1st floor in the Blue Jay Way home area, 5 pagers were found in a desk drawer at the nurse's station and only one PSW was wearing her pager.

- The home's policy requires staff to sign out their pagers in a log book. The log book on the 2nd floor was mostly blank for the entire year of 2010 for most of the pagers. The log book in the Blue Jay Way nurse's station, was very spotty, with very few staff signing out their pagers. The last entries in the log book for some pagers was in Oct and Nov of 2010.

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 with s.17(1)(f) in respect to ensuring that the home is equipped with a resident-staff communication and response system that clearly indicates when activated where the signal is coming from, to be implemented voluntarily.

WN #6: *The licensee has failed to comply with O. Reg. 79/10, s. 9.1.i & iii., A. & B.* 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 must be,
 - i. kept closed and locked,
 - 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.

Findings:

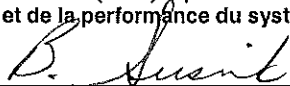
None of the doors leading to stairwells and to outside areas of the home are connected to the resident-staff communication and response system, are not equipped with an audible door alarm and are not connected to an audio visual enunciator that is connected to the nurses' station nearest to the door.

- Only one audio visual enunciator panel is located in the home for all of the doors and is located in the Fountain View home area. This area is remote to many of the other areas in the home and nursing staff are not permanently assigned to this station to monitor the enunciator panel. This panel was observed to ring incessantly (due to an interior door that was never disengaged from the system) and none of the staff responded to the panel. Staff were questioned about the "ringing" sound and they said that they have learned to ignore it and that it doesn't bother them. None of the other nurse's stations/offices in the home have enunciator panels which would be closest to the doors they are to monitor.
- The second floor has multiple doors leading to stairwells, which when left open, do not audibly alarm and are not connected to an audio visual enunciator at the nurses station on the second floor, as one has not been installed. The staff in Fountain View would have to call the nurse's station on the 2nd floor to alert them that a door is open.

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 with s.9.1 i & iii, A & B in respect to

ensuring that all doors leading to stairways and the outside of the home be kept closed and locked, equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident-staff communication and response system or 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. The plan is to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné		Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. 
Title:	Date:	Date of Report: (if different from date(s) of inspection). <i>Feb. 11/11</i>