Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 21, 22, 23, 26, 27, 28, 2012	2012_204133_0006	Complaint

Licensee/Titulaire de permis

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

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

CARLINGVIEW MANOR
2330 CARLING AVENUE, OTTAWA, ON, K2B-7H1

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Environmental Manager, housekeeping and nursing staff and a resident

During the course of the inspection, the inspector(s) observed resident washrooms throughout the home, reviewed policies and job routines related to the housekeeping department

The on-site inspection occurred November 21,22,23 - 2012

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services
Specifically failed to comply with the following subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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 comply with LTCHA, 2007, c.8, s.15 (2) (a) in that equipment and surfaces in identified resident washrooms are not being kept clean and sanitary.

On 6 of 7 care units, the inspector observed resident washrooms which are shared by two or more residents. The following was noted over the course of the inspection in 23 shared washrooms:

In 15 washrooms, the raised toilet seat fixture and/or the toilet was dirty with dried fecal matter and/or dried urine and/or dried yellowish/beige matter and/or debris in identified locations (for example: on the front horizontal metal bar below the raised toilet seat; on the outer front leg of the raised toilet seat fixture; on the toilet tank near the flusher; on/around the base of the toilet).

In 11 washrooms, lower walls surrounding toilets and/or around toilet paper dispensers and/or around the garbage can and/or below sinks were dirty with dried fecal matter and/or other dried matter.

In 2 washrooms, there was a heavily soiled toilet cleaning brush with fecal matter embedded within the bristles.

In 1 washroom, there was dried fecal matter on the back of a transfer pole next to the toilet and a light beige cloth bag hanging on the transfer pole that was in contact with the toilet and soiled with yellow stains and brown splatter spots. In this particular washroom, there was areas of dried fecal matter on a corner of a shelving unit in a corner of the washroom.

2. The licensee has failed to comply with LTCHA, c.8, s.15 (2)(c) in that furnishings in identified resident washrooms are not maintained in a safe condition and in a good state of repair.

The inspector observed, in 4 resident washrooms, that the front lower rim of the sink counter top is damaged. The laminate surface is missing in areas and the particle board beneath is exposed. The particle board is rough and splintered and could pose a safety concern if bare frail skin was up against it. The particle board is absorbent and therefore cannot be cleaned and disinfected.

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 the requirement that the home, furnishings and equipment are kept clean and sanitary and the requirement that home, furnishings and equipment are maintained in a safe condition and good state of repair., to be implemented voluntarily.

WN #2: 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 subsections:

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 comply with O. Reg 79/10, s. 229 (4) in that all staff do not participate in the implementation of the infection control program. Staff failed to remove towels soiled with dried fecal matter from a resident washroom between 12:30pm on November 22, 2012 and 9:15am on November 23, 2012.

On November 22, 2012 at approximately 12:30pm, the inspector entered the washroom in an identified bedroom. Four residents reside in this bedroom and share the washroom. The inspector observed two white hand towels soiled with dried fecal matter resting on the back right side of the toilet seat and a third white hand towel soiled with dried fecal matter hanging on a hook above a resident's towel bar. The garbage can was filled past the top with toilet paper and paper towel.

On November 22, 2012 at approximately 4:30pm, the inspector returned to the washroom in the identified bedroom and noted that the soiled towels remained in place and the garbage can was now over-flowing , with pieces of toilet paper lying on the floor all around the garbage can.

On November 23, 2012 at approximately 9:15am, the inspector returned to the washroom in the identified bedroom accompanied by the Administrator. The inspector observed that the garbage can was now empty and the two white hand towels soiled with dried fecal matter that had been resting on the back of the toilet seat were now on the floor, behind and to the right of the toilet. The soiled towel hanging on a hook above a residents towel rack remained in place.

On November 23, 2012, in the presence of the Administrator, the inspector spoke with the housekeeper assigned to the care unit(staff #100). The housekeeper confirmed that the washroom in the identified bedroom had not been cleaned on November 22, 2012 due to time constraints. The housekeeper indicated that they had emptied the washroom garbage on the morning of November 23, 2012 and had seen the soiled towels when doing so. The housekeeper stated that nursing staff should be routinely checking the bedrooms and washrooms and they felt it was the responsibility of nursing staff to pick up such items. The Administrator re-instructed the housekeeper at that time, stating that nursing staff and housekeeping staff have a shared responsibility here as this is a matter of infection prevention and control.

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 the requirement that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #3: 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. As per O. Reg 79/10, s.87(2), as part of the home's organized program of housekeeping, under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for cleaning of the home.

At the time of the inspection, the housekeeping program at the home is described in policies and procedures from the Nova Services Group Inc. The inspector reviewed policy "ES B-15-10" titled "Light duty cleaner daily & unit cleaning procedure" and policy "ES C-10-05" titled "General cleaning procedures daily cleaning sequence". These policies set out that resident's washrooms will be cleaned daily.

On November 22, 2012 at approximately 12:30pm, the inspector entered the washroom in an identified bedroom. Four residents reside in this bedroom and share the washroom. The inspector observed that there were two white hand towels soiled with dried fecal matter resting on the back right side of the toilet seat and a white hand towel soiled with dried fecal matter hanging on a resident's towel rack. The garbage can was filled past the top with toilet paper and paper towel. An accumulation of black liquid was observed on the back of the toilet base, right and left sides. There was dried beige matter along the lower outer right leg of the toilet arm rest. The sink was heavily soiled with dried toothpaste and other residue. One of the residents who resides in the room (resident #001) pointed out two areas of dried fecal matter on the wall to the left of the toilet, near the toilet paper dispenser, and said to the inspector that the bathroom was often in such a condition.

On November 22, 2012 at approximately 4:30pm, the inspector returned to the washroom in the identified bedroom and noted that the soiled towels remained in place and the garbage can was now over-flowing, with pieces of toilet paper lying on the floor all around the garbage can. The washroom had not been cleaned.

On November 23, 2012 at approximately 9:15am, the inspector returned to the washroom in the identified bedroom accompanied by the Administrator. The inspector observed that the two white hand towels soiled with dried fecal matter that had been resting on the back of the toilet seat were now on the floor, behind and to the right of the toilet. There was no toilet paper left on the dispenser. The washroom had not been cleaned, but the garbage can had been emptied.

On November 23, 2012, in the presence of the Administrator, the inspector spoke with the housekeeper assigned to the care unit (staff #100). The housekeeper confirmed that they had emptied the garbage can in the washroom in the identified bedroom that morning. The housekeeper confirmed that the washroom in the identified bedroom had not been cleaned the previous day due to time constraints.

The licensee has failed to comply with O. Reg 79/10, s.8 in that the policy in place to clean resident's washrooms daily was not complied with.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 87(2)(d) in that procedures to address incidents of lingering offensive odours have not been effectively implemented.

Over the course of the 3 day inspection, the inspector noted a strong and lingering urine odour in the washroom in an identified bedroom. The Administrator accompanied the inspector to this washroom on the last day of the inspection and also noted the strong urine odour.

Issued on this 29th day of November, 2012

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

Jessica Lapensée