Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 13, 2013	2013_295556_0001	O-000980-13	Other

Licensee/Titulaire de permis

DEEP RIVER AND DISTRICT HOSPITAL
117 BANTING DRIVE, DEEP RIVER, ON, K0J-1P0

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

THE FOUR SEASONS LODGE
117 BANTING DRIVE, DEEP RIVER, ON, K0J-1P0

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

WENDY PATTERSON (556)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): November 12, 2013.

This was a Service Area Office Initiated Inspection. Paula MacDonald Inspector #138 was present for the purpose of orientation.

During the course of the inspection, the inspector(s) spoke with The Administrator/Director of Care, Dietitian, Registered Practical Nurse (RPN), Personal Support Workers (PSW), President of the Resident's Council, several residents.

During the course of the inspection, the inspector(s) reviewed several months of Resident Council minutes, conducted a tour of resident and non-resident areas of the home, observed resident care and staff/resident interactions, and observed a meal service.

The following Inspection Protocols were used during this inspection:
Dining Observation

Residents' Council

Findings of Non-Compliance were found during this inspection.

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. On November 12, 2013 at 10:10am Inspector #556 observed the door to the soiled utility room to be closed with the door handle in the locked position, however the lock had not engaged and the door was easily pushed open. Prior to leaving the area Inspector engaged the lock and checked to ensure the door was secure. There were no staff in the area.
At 10:31am the inspector checked the door of the soiled utility room and again found the door to be easily pushed open. The soiled utility room contained laundry detergent, heavy duty general cleaner, a sharps container with sharps, odour eliminator, hand sanitizer, a washer and dryer, and laundry baskets containing soiled clothing.
Inspector interviewed RPN Staff #102 about the soiled utility room door and he/she stated that the door is to be locked to prevent unsupervised access, and that there are washers and dryers in the soiled utility room for Residents to use under staff supervision but none of the residents use them.
At 11:40am Inspector interviewed the Administrator who stated she was not aware that there was a problem with the door but would contact maintenance to have it repaired.
Maintenance was observed working on the door at approximately 11:45am and the door was locked when tested by the Inspector.
As such the licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff. [s. 9. (1) 2.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. On November 12, 2013 Inspector #556 inspected several resident bathrooms. In one shared bathroom in a room shared by 4 residents, there was a container of unlabelled deodorant and an unlabelled bar of soap at the sink, as well as unlabelled mouthwash and unlabelled powder on a shelf on the wall.
Inspector interviewed RPN Staff #102 who stated he/she did not know who the unlabelled deodorant or the bar soap at the sink belonged to, but indicated there was a resident in that room who goes in to the bathroom and rummages around. Staff #102 stated that when soap is left at the sink staff will throw it out because they don't know who it belongs to.
PSW Staff #101 was interviewed and he/she stated that the bar of soap at the sink in the shared bathroom is not identified and would normally be thrown out. He/she also stated that he/she had no idea who the unlabelled deodorant sitting on top of the dresser in the shared bathroom belongs to. Staff #101 stated that two residents in the ward room can access the bathroom on their own and that Resident #001, who has resided in the home since early 2010, was known to go in to the bathroom and rummage through the drawers taking items out, but that he/she was unable to put them back where he/she found them.
Inspector observed that Resident #001 has use of a drawer in the dresser of the shared bathroom and that nothing in Resident #001's drawer was labelled. Staff #101 stated that the normal practise in the home is to have all personal items labelled and anything found sitting out that was not labelled was thrown away.
During an interview with the Administrator she indicated that there is a general problem with labelling of resident personal items because there have been some new staff hires and all the details have not been worked out yet.
While the Inspector was in the home the staff removed the unlabelled deodorant, bar soap, mouthwash, and powder from the shared bathroom, however the personal items in Resident #001's drawer in the shared bathroom had not been labelled, these included skin lotion, personal cleanser, comb, and deodorant.
As such the Licensee has failed to ensure that each resident of the home has his or her personal items labelled within 48 hours of admission and of acquiring, in the case of new items; [s. 37. (1) (a)]

Issued on this 14th day of November, 2013

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