Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 27, 28, 29, 30, Oct 6, 7, 12, 25, 28, 2011	2011_036126_0030	Complaint Log # O-001280-11

Licensee/Titulaire de permis

GENESIS GARDENS INC
438 PRESLAND ROAD, OTTAWA, ON, K1K-2B5

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

FOYER ST-VIATEUR NURSING HOME
1003 Limoges Road South, Limoges, ON, K0A-2M0

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

LINDA HARKINS (126)

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 son's Administrator, the Director of Care, the Assistant Director of Care,the evening full time Registered Nurse, four Health Care Aides, Activity Manager and the resident.

During the course of the inspection, the inspector(s) reviewed the resident health care record and observed care and services provide to the residents

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Nutrition and Hydration

Personal Support Services

Recreation and Social Activities

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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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 ensure the home, the furnishing and equipment are kept clean and sanitary.
2. In a specific resident's bathroom it is observed that the caulking around the base of the toilet and the floor tile seams are dirty with brown matter. The brown matter has an appearance and consistency of rust and was partially removed when wiped with a damp paper towel. This brown matter is also noted along the seam of two floor tiles to the left of the toilet. s.15.(2)(a)

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' desired bedtime and rest routine is individualized to promote comfort , rest and sleep.
2. The evening of September 27, 2011, 43 residents out of 57 residents were observed to be in their night wear by 18:43 and 5 residents were in bed for the night.
3. Family member visiting her mother stated that almost every resident is in night wear after supper. The visitor has never been asked if it is acceptable for her mother to be put in her night wear at that time.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following subsections:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program;
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends;
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests;
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities;
(e) the provision of information to residents about community activities that may be of interest to them; and
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the recreation and social activities program include schedule activities that are offered during the evening.
2. On the evening of September 27, 2011, no evening activity was observed. Several residents were wandering in the hallway.
3.Discussion with the Activity Program Manager and she stated that the home does not have activity program in the evening. r.65(2)b

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

Specifically failed to comply with the following subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to set out clear directions for the staff and others to ensure residents eat their 3 meals a day.
2. The daily flow sheet indicate that a resident refused one meal a day more than half of the time for the last 5 months.
3. The licensee has failed to ensure that the Registered Dietitian has completed the nutritional assessment whenever there is a significant change in the resident's health condition.
4. The MDS assessment and the dietary quarterly of August 2011 does not reflect the resident refusal to eat one meal a day.

Issued on this 28th day of October, 2011

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