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

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
Oct 10, 2014	2014_260521_0043	L-001313-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF LAMBTON
789 Broadway Street, WYOMING, ON, N0N-1T0

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

LAMBTON MEADOWVIEW VILLA
3958 PETROLIA LINE, R. R. #4, PETROLIA, ON, N0N-1R0

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

REBECCA DEWITTE (521), ALI NASSER (523), JOAN WOODLEY (172)

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 29, 30 and October 1, 2, 3, 6, 7 and 8

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, 3 Registered Nurses, 7 Registered Practical Nurses, 9 Personal Support Workers, 3 Life Enrichment Workers, 1 Environmental Supervisor, 1 Nutritional Manager, 1 Social Worker, 1 Dining Assistant, 1 Confidential Clerk, 3 Family Members, 1 Resident Council Representative, 1 Family Council Representative and 40+ Residents

During the course of the inspection, the inspector(s) conducted a tour of all resident areas and common areas, observed residents and the care provided to them and observed meal services. Medication administration and storage were observed and clinical records for identified residents were reviewed. Policies and procedures of the home were reviewed along with observations of general maintenance and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care
Sufficient Staffing
Training and Orientation

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 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).

Findings/Faits saillants :

1. The licensee 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 as evidenced by;

A Resident interview on September 30, 2014, in Stage 1 of the Resident Quality Inspection revealed a regular staff member who was abrupt and rude to the Resident.

An interview on October 6, 2014, with a staff member revealed there was a regular staff member who was known to treat Residents abruptly and rudely. The staff member has reported her findings to the Registered Staff on duty on several occasions in the past.

An interview on October 06, 2014, with the Registered Staff revealed reports of a regular staff member treating Residents abruptly and rudely have been received and the Registered Staff have spoken to the staff member regarding the treatment of the Residents. The Registered Staff confirmed this has not been further reported to the management.

An interview with the Director of Care confirmed it is the homes expectation that all Residents rights are fully respected and promoted. [s. 3. (1) 1.]

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 the rights of residents are fully respected and promoted, to be implemented voluntarily.

WN #2: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 failed to ensure that the plan of care is based on an assessment of the Resident and the Resident's needs and preferences, as evidenced by;

On September 30, 2014, a Resident observation revealed that the Resident had a seating device.
A review of the clinical record revealed that the resident received an Occupational Therapist Assessment, adjustment parts were ordered, applied and evaluated.

A review of the care plan revealed no information, goals or interventions about the device.

The Administrator and the a Supervisor both confirmed in an interview that it is the home's expectation that the plan of care be based on an assessment of the Resident and the Resident's needs and preferences. [s. 6. (2)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the Resident as specified in the plan, as evidenced by;

The Resident's life enrichment care plan stated : "Resident receives one to one, treatment weekly with Life Enrichment staff".

Upon review of the activity report from July 2, 2014 to September 29, 2014 it was revealed that the Resident received 5 "visits" when they should have received 15 visits.
A Supervisor confirmed in an interview that the Resident received only 5/15 visits and that the home's expectations is that the Resident should have received the visits as set out in the plan of care. [s. 6. (7)]

3. The licensee failed to ensure that the care set out in the plan of care was provided

to the Resident as specified in the plan as evidenced by;

A record review of Resident Care Plan revealed - Assess Resident twice weekly with bathing and with all personal hygiene. Notify Team Leader of any issues identified in the assessment.

The record review revealed last months assessments were not completed on September 09, 12, 19, 23, 26 2014.

An interview with the a Manager confirmed that the assessments were not completed as set out in the plan of care and that it is the homes expectation to complete the care that is set out in the 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 the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident and is provided to the resident as specified in the plan, 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:

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is and is complied with as evidenced by;

An interview on October 03, 2014, with a Personal Support Worker revealed the oral care of Resident was not completed by that Personal Support Worker.

A record review revealed the Personal Support Worker had documented oral care had been completed on Resident on October 03, 2014.

A further interview with the Personal Support Worker revealed the documentation was completed on behalf of another Personal Support Worker on duty bathing Resident on this same date.

Policy - Nursing 3-5-4-5 Documentation Page 3/4 point 5 states "The unregulated care providers PSW/HCA will record the care they provide in Point of Care."
The Director of Care confirmed it is the homes expectation that all staff document their own assignments. [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 licensee has in place any plan, policy, protocol, procedure, strategy or system is in compliance with applicable requirements under the Act; and is complied with, to be implemented voluntarily.

WN #4: 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 failed to ensure that the home, furnishings and equipment are kept clean and sanitary as evidenced by;

On September 30, 2014, Observations in bathroom revealed a dirty commode and a plunger on the floor.

In a bathroom the toilet was smeared in a bowel movement with a urinal resting on the back of the toilet, the used toilet paper was on the floor. This was confirmed by the Personal Support Worker.

On October 02, 2014 Observations in a bathroom revealed a dirty commode and a plunger on the floor. This was confirmed by the Register Staff on duty.

On October 03, 2014, Observations in a bathroom revealed the toilet soiled with a bowel movement. This was confirmed by the Personal Support Worker. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair as evidenced by;

Throughout the Resident Quality Inspection process observations revealed:

a) Floor 1: Water damage marks and peeled paint on ceiling over a nursing station, and a rusted air vent.

b) Damaged wall beside sink.

c) Peeled paint around hand sanitizer dispenser, bubbling vinyl floor under and around bed, marks of bed wheels.

d) Lifting floor under and around bed foot rest.

e) Lifting floor under bed foot rest, stained ceiling tile in bathroom, dusty bathroom air vent.

f) Stained tile in bathroom.

g) Wall damage behind chair.

h) Stained ceiling in the 3rd floor hallway by the elevators and between dining room and nursing station.

The areas of disrepair were confirmed by the a Supervisor on October 8, 2014. [s. 15. (2) (c)]

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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres, as evidenced by;

During stage 1 of the Resident Quality Inspection it was noted that windows opened 24 centimeters to the outside. This was confirmed by the Administrator and the a Supervisor.
[s. 16.]

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 window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with as evidenced by;

A Resident interview on September 30, 2014, in stage 1 of the Resident Quality Inspection revealed there is a regular staff member who is abrupt and rude to the resident.

An interview with a staff member revealed there is a regular staff member who is known to treat Residents abruptly and can be rude. The Staff member has reported her findings to the Charge Nurse on duty on several occasions within the year.

An interview on October 06, 2014, with Registered Staff revealed reports of a regular staff member treating Residents abruptly and rudely have been received and the Registered Staff has spoken to the staff member regarding the treatment of the Residents. The Registered Staff explained the staff member concerned usually behaves better after the Registered Staff has addressed the behaviour with her personally.
The Registered Staff confirmed this has not been further reported to management as per policy Prevention of Abuse and Neglect to Residents 2-8-18 Revised 02/2012 Page 2/10 point 3.

An interview with the Director of Care verified the Registered Staff has not reported the complaints of abrupt and rude treatment to the Director as per the policy. [s. 20. (1)]

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 in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #7: 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 is a written record of each annual evaluation of the staffing plan, as evidenced by;

A review of the home's staffing plan revealed that there was no documented evidence of a written record of an annual evaluation of the staffing plan.
This was confirmed by the Administrator in an interview. [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 there is a written record of each annual evaluation of the staffing plan, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the Resident's hygiene requirements, unless contraindicated by a medical condition as evidenced by;

An interview with the Director of Care on October 08, 2014 revealed a Resident who refused a bath had not been offered a documented substitute bath at another time.

In September, 2014, the Resident was offered a total of 7 baths, 4 baths were refused by the Resident (57%) and no further bathing was provided or documented.

The Director of Care confirmed it is the homes expectation that the Residents receive a bath at a minimum of twice per week. The Director of Care explained it is the homes expectation that when a Resident refuses a bath the staff will re-approach the Resident at another time. [s. 33. (1)]

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 resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, to be implemented voluntarily.

WN #9: 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:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

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:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that Residents are monitored during meals.

Observations on October 6, 2014, revealed:

Residents were left unattended in the dining room with food and fluids still in front of them. 1 staff member was taking Residents back to their rooms at end of meal service and the other Personal Support Worker working was at the end of the hall assisting another Resident.
No registered staff were in attendance in the dining room. The door into the servery was closed and the dietary staff were not monitoring the Residents.
This was confirmed by the staff.

An interview with Director Of Care confirmed it is the home's expectation that Residents are not to be left unattended in the dining room with food or fluids available to them. [s. 73. (1) 4.]

2. A third dining room observation made on October 08, 2014, revealed Residents were observed in the dining room unsupervised by staff.
The door into the servery was closed.
A Resident was still eating the toast.
The staff confirmed the Residents were left in the dining room unattended and 1 was still eating toast.

A staff interview with a Registered Nurse confirmed there was no staff in the dining room and it is the home's expectation that a member of the staff be in the dining room as long as there are still Residents eating and drinking in the dining room. [s. 73. (1) 4.]

3. The licensee failed to ensure that meals are served course by course unless otherwise indicated by the Resident or the Resident's assessed needs.

A Resident observation on October 6, 2014, at noon meal revealed, a Resident was served soup and then was offered a dessert of which they picked jello and a butter tart.
A staff interview with a manager confirmed desserts should not be served before the entree is served to a Resident. [s. 73. (1) 8.]

4. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat, as evidenced by;

On September 30, 2014, at 1200 hours a Resident was observed in the dining room seated in a chair that was significantly lower than the dining chairs resulting in the table height for the meal being disproportionate.

The Resident was required to eat the meal with the elbows extended upwards at a 10 - 2 position. This was bought to the attention of the Registered Staff on duty. The Registered staff claimed this was a one time meal event for this Resident.

An interview with the staff revealed the Resident has been using this chair more frequently.

On October 02, 2014 at 1200 hours a Resident was observed in the dining room on the 3rd floor seated in a chair significantly lower than the table and other dining chairs to eat the meal provided.

This was bought to the attention of the Registered staff on duty.
The Registered staff on duty asked the Resident if they were uncomfortable and would like to eat sitting in another dining chair. The Resident confirmed they were uncomfortable and proceeded to be seated in another dining chair for the remainder of the meal.
The Registered staff confirmed it is the homes expectation that Residents are seated comfortably and at the appropriate height to eat. [s. 73. (1) 11.]

5. The licensee failed to ensure that the Residents who require assistance with eating and drinking are only served a meal when someone is available to provide the assistance.

On October 6, 2014, all Residents had been served their soup by the dietary aide even though no Nursing staff were present in the dining room to feed those Residents that needed assistance.

A staff interview with a staff member confirmed the soup was served at 1200 hours as the Residents are to begin lunch at 1200 hours.
Staff interviews with other staff revealed the soup is served prior to them being ready to assist a Resident so that there is time for the soup to cool and the crackers can absorb the soup.

Resident observations revealed some Residents waited 12-20 minutes before a staff member was available to help them with eating their soup. [s. 73. (2) (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 monitoring of all residents during meals, a course by course service of meals for each resident, appropriate furnishings and equipment in resident dining areas and no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #10: 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. (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 failed to seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results as evidenced by;

An interview with a Residents' Council member revealed the licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

A review of the Residents' Council meeting minutes revealed there was no documentation regarding advice of the Residents' Council in developing the satisfaction survey.

An interview with the Administrator confirmed the licensee has not obtained the advice of the Residents' Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

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 the licensee seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results annually, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

Resident observations revealed a Registered staff drawing up medication into the syringe, recapping and placing the syringe in the coat pocket of the resident going out on an leave of absence.

A review of Resident physician's orders revealed:

a) no order for Leave Of Absence, or Leave Of Absence with medications

b) no order for self administration

c) an order for testing before meals and a change may be required.

A further chart review revealed a self administration of medication assessment was completed for a Resident for other medications only.

The Director of Care confirmed it is the homes expectation that all Residents self administering medications have an order from the prescriber to self administer the medication. [s. 131. (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 no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #12: 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. (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 failed to ensure that all staff participate in the implementation of the infection prevention and control program as evidenced by;

Observations throughout the Resident Quality Inspection process revealed:

a) a call bell was on the floor, this was confirmed by a staff member who stated that the home's expectations is to have the call bell off the ground for infection prevention and control purposes.

b) a call bell was attached to bed but dangling in garbage bin. The call bell in bathroom on the floor.

c) a call bell in bathroom on the floor.

d) unlabeled personal care items in shared bathroom, a call bell was on the bathroom floor.

e) a call bell attached to bed but on the floor, the call bell in bathroom on the floor.

This was confirmed by the Administrator who stated that the home's expectations is to have the call bells off the ground for infection prevention and control purposes.

f) an unlabeled deodorant and peri-wash bottle in a shared bathroom. This was confirmed by staff who stated that the home's expectation is to have all personal care items labelled in the shared bathroom. [s. 229. (4)]

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

On September 30, 2014, a staff member was observed to offer nourishment and water to Residents. The staff member took the glass of water to the bathroom where they poured the water away and refilled the glass with water from the jug, while still in the bathroom.

It was confirmed with Registered staff, in an interview that the home's expectation is to have the water poured from the glass in the container attached to the nourishment cart and fresh water will be provided to the resident poured at the cart side and not in the bathroom. [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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #13: 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. The licensee failed to 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 as evidenced by;

On October 02, 2014, observations in a shared bathroom revealed un-labelled storage space containing an un-labelled tooth brush and an un-labelled cup containing un-labelled products.

The Registered staff on duty confirmed these personal items were not labelled and it is the homes expectation that all personal items are labelled. [s. 37. (1) (a)]

WN #14: 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 the Resident's desired bedtime is being supported as evidenced by;

A review of the Resident's care plan revealed that the Resident's usual bedtime is specified.

An interview with a Resident's spouse revealed that on several occasions they came to visit the resident and they found them already in bed, the curtains were closed and the lights were off earlier than the requested bed time.

In an interview with the Administrator it was confirmed that it is the home's expectations that the Resident's desired bedtime and rest routine be supported to promote comfort, rest and sleep. [s. 41.]

Issued on this 20th day of October, 2014

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