



**Ministry of Health and  
Long-Term Care**

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

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

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

**Health System Accountability and  
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**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité**

### **Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Mar 14, 2014	2014_258519_0006	L-000193-14	Resident Quality Inspection

#### **Licensee/Titulaire de permis**

SAINT LUKE'S PLACE  
1624 Franklin Blvd., CAMBRIDGE, ON, N3C-3P4

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

SAINT LUKE'S PLACE  
1624 FRANKLIN BOULEVARD, CAMBRIDGE, ON, N3C-3P4

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

SHERRI GROULX (519), DEBORA SAVILLE (192), INA REYNOLDS (524), NUZHAT  
UDDIN (532)

### **Inspection Summary/Résumé de l'inspection**



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**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): February 24, 25, 26, 27, 28, March 5, 6, 2014**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care and Infection Control Coordinator, the Director of Recreation Services, the Director of Support Services, the Financial Officer, the Lead Registered Nurse on Continence, Falls, and Wounds, Registered Nurses, a Behavioural Supports Ontario (BSO) Registered Practical Nurse, Registered Practical Nurses, a Behavioural Supports Ontario (BSO) Personal Support Worker, Personal Support Workers, a Receptionist, a Hairdresser, Maintenance Staff, a Housekeeper, a Cook, Dietary Aids, and Residents.**

**During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas and care provided residents, reviewed medication records and plans of care for specified residents, reviewed policy and procedure, observed recreational programming, staff interaction with residents and general maintenance and cleaning of the home.**

**The following Inspection Protocols were used during this inspection:**



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**Accommodation Services - Housekeeping  
Accommodation Services - Laundry  
Accommodation Services - Maintenance  
Admission and Discharge  
Continence Care and Bowel Management  
Dignity, Choice and Privacy  
Dining Observation  
Falls Prevention  
Family Council  
Food Quality  
Infection Prevention and Control  
Medication  
Personal Support Services  
Prevention of Abuse, Neglect and Retaliation  
Quality Improvement  
Reporting and Complaints  
Residents' Council  
Responsive Behaviours  
Skin and Wound Care**

**Findings of Non-Compliance were found during this inspection.**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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:**
- 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 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:

#8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

During observation in a dining room located in the home by a Long Term Care Home Inspector it was noted that residents received their medical treatments while seated at the dining room tables and in front of their co-residents.

During observation of a medication pass in a dining room it was observed that some residents received monitoring and medical treatments while seated in the dining room, and in front of co-residents.

Interview with staff indicated that the physician had specifically ordered these medical treatments to be given to the identified residents with their meals.

During an observed meal service a medical treatment was given to a resident at 1200 hours. Meal service did not start until 1240 hours. The resident was provided a medical treatment forty minutes prior to meal service which would conflict with the statement made by the registered staff member.

Record review including the physician order, plan of care and Medication Administration Record (MAR) confirm that there is no order for four of five residents reviewed to receive their medical treatment in the dining room, with the meal. Orders for the Resident indicated that the resident should receive their medical treatment before breakfast and before lunch with a time frame of 1130 hours identified in the MAR.

Interview with the Director of Care confirmed that there is no policy related to residents receiving medications in the dining room, but that it is the home's practice that medication would only be administered to a resident in the dining room if it was included in the plan of care.

The licensee failed to ensure that residents are provided privacy in treatment and in caring for their personal needs. [s. 3. (1) 8.]



***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 ensuring that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.***

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**WN #2: 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).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that policies and procedures for "Meal Times" are complied with.

The policy titled "Meal Times" dated as revised February 2013 stated:  
Serve milk, juice and bread not in excess of ten minutes prior to mealtime when residents are present and at no time are meals or beverages served to resident's tables when residents are absent.

In addition, a posting on the bulletin board in the servery area addressed to Food Service Personnel identified that a choice of juice was to be offered at all meals. You will wait until the resident is seated and ask what kind of beverage they would like with their meal.

During a lunch meal service it was observed that at all tables in a dining area, milk, juice, water and soup had been served. No residents were present in the dining room. At 1215 hours residents were allowed into the dining room. Choice of juice was not



offered to any resident entering the dining room. [s. 8. (1) (b)]

2. The Licensee had failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The policy titled "Meal Service Table Rotation", # D313 dated as revised February 2013 stated: The food serving worker will ensure a table rotation is performed at lunch and supper meal to ensure each resident has the opportunity to be served first. Each week, begin on the day of the week indicated and serve that table listed.

During the supper meal service in a dining room, staff did not follow the Table Rotation schedule as posted in the dining room.

The resident Dining Room Committee meeting minutes indicated that residents have raised concerns regarding table rotation service dating back to October 25, 2013. Interview with the Director of Support Services confirmed her expectation that staff follow the table rotation schedule to ensure each resident has the opportunity to be served first. [s. 8. (1) (b)]

3. The licensee failed to ensure that 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, is complied with.

The policy titled "Resident/Family Complaint/Resolution Procedure", # A-07-II-55 dated as reviewed March 2013 stated: The concerned party will be notified in writing of the outcome of the complaint investigation.

Record review and interview with the Administrator confirmed that the Home does not provide written responses to verbal or written complaints. [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 ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.***

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**WN #3: 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).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

During tour of the home it was observed that there was debris on the floor of the sun room at the end of a corridor; shower/tub room floors were badly soiled and appeared blackened in corners, near walls, around toilets, and inside showers; equipment in the tub/shower room was noted to appear dirty around the base of the equipment, lift and tub legs, loose debris under and behind the tub.

During tour of the home it was observed that floors in the tub/shower rooms remain discoloured and appear unclean. There is a build up of dirt in corners, at the door frame and around the room. Debris continues to litter the floor in the sun room at the end of the corridors, the floor of the elevator is noted to have loose debris and appears unclean. The legs of the tubs and tub lifts, and corridors, are dirty, with white substance on the legs, loose debris under and behind the tub.





Interview confirmed that Housekeeping staff are not responsible for the cleaning of lifts. Interview identified that the home plans to replace flooring in both tub/shower rooms, but no schedule for the repair is known. Staff are currently attempting to clean the floor surfaces with routine cleaning once daily. It is unclear who is responsible for cleaning the stationary parts of the tub and base of the lift and the floor under and around the tub and the lift.

The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During the tour of the home and in the presence of maintenance staff the following was observed:

some dining room table legs were scarred and marked, the finish was worn off, the fire place had dirt caked at the edge, legs of chairs were marked and scuffed, three cupboard doors had finish wearing off and chairs and other furnishings in common areas were marked and noted to be in poor condition. In the tub and shower room the floor was grey stained and had blackened floor around the edges, in corners and appeared unclean.

In a tub room the floor was a dirty grey stained colour, a hole on the wall beside the shower room was noted, the floor was grey stained around the toilet area, the wall had scratch marks, and the dry wall beside the bathroom was chipped off.

Record review and maintenance staff confirmed that there was no preventative maintenance procedure in place to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. [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 ensuring that the home, furnishings and equipment are kept clean and sanitary and in a good state of repair, to be implemented voluntarily.***



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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care**

**Specifically failed to comply with the following:**

**s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that residents received finger nail care, including the cutting of fingernails.

A) Resident observations revealed that a resident's fingernails were long and unclean. The plan of care review and interview with a staff member revealed that the resident is to have a manicure on bath day, however, the record review revealed that the resident did not receive fingernail care on bath days. (532)

B) A Resident was observed to have long finger nails that were unclean. The plan of care and interview confirmed that this resident would receive nail care at the time of their bath. Review of the flow sheet indicated that the resident received a bath recently. There was no documentation that nail care was completed. Interview confirmed that the bath and nail care would be documented on the flow sheet and or the Resident Skin Assessment form.

C) The plan of care for a resident indicates that the resident is to have a manicure on bath days.

This Resident was observed to have long fingernails with dirt noted under some nails. The resident's hands were unclean and sticky.

The resident continued to be observed having long, sharp, nails with dirt noted under the nails and remnants of nail polish on some nails after the bath was supposed to be completed.

A Resident did not receive fingernail care including the cutting of fingernails.

The policy titled "Resident Personal Care/Bathing", # N-I-J-10 dated as revised February 2006 indicates that during the resident's routine personal care/bathing, the Aide will inspect the resident's nails (feet and hands) for necessary trimming. [s. 35. (2)]



***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 ensuring that all residents receive fingernail care, to be implemented voluntarily.***

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**WN #5: 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:**

**1. Communication of the seven-day and daily menus to residents. 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).**

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**Findings/Faits saillants :**

1. The Licensee had failed to ensure the weekly menus were communicated to residents.

During meal observations in various dining rooms the weekly Fall-Winter menu for week two was not posted and/or communicated to residents.

This was confirmed by the Director of Support Services. [s. 73. (1) 1.]

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

During an observed meal service in a dining room, it was confirmed that staff begin to porter residents to the dining room at 1215 hours. It was noted that soup had been



placed on all tables prior to residents arriving in the dining room. Residents did arrive and were seated between 1218 hours and 1235 hours. At this time the staff requested the show plates for service of the main course and proceeded to provide the main course to residents in the dining room. Soup bowls had not been removed. At 1250 hours dessert was served to residents, providing choice but not without having cleared the soup, or main course. It was noted that some residents were still eating their first course, had their main course sitting in front of them and were provided their dessert.

The lunch meal was not served course by course. [s. 73. (1) 8.]

3. The Licensee had not ensured that meals were served course by course.

During a lunch meal service in a dining room the main entrées were offered and served while residents were still eating their soup.

During an observed supper meal service in a dining room desserts were offered and served while residents were still eating their main course. The staff member stated the entrée plates are cleared away after nursing staff document the residents' Food and Fluid Intake records.

During an observed breakfast meal service in a dining room the main entrees were offered and served while residents were still eating their cereal.

A review of the home's Meal Service policy, # D305 dated as reviewed February 2013, and interview with the Director of Support Services confirmed the expectation that meals are served one course at a time; specifically, dishes from one course are cleared before the next course is served. [s. 73. (1) 8.]

4. The licensee failed to ensure that meals were served course by course.

During a lunch meal service it was observed in a dining room empty soup bowls along with main course and dessert were sitting on the table. The staff was observed coming out of the servery to deliver the meal choices to individual residents, however, the staff member was not observed clearing dishes before serving the next course. The staff failed to follow the policy to ensure that meals were served course by course.



A review of the home's Meal Service policy, # D305 dated as reviewed February 2013 under Meal Delivery states that dishes from one course are cleared before the next course is served. [s. 73. (1) 8.]

***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 ensuring that the weekly menus were communicated to residents and that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs, to be implemented voluntarily.***

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**WN #6: 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. (2) The licensee shall ensure,**

**(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program; O. Reg. 79/10, s. 229 (2).**

**s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).**

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**Findings/Faits saillants :**



1. The licensee failed to ensure that there was an interdisciplinary team approach in the coordination and implementation of the Infection Prevention and Control Program.

Upon interview, it was revealed that there was no interdisciplinary Infection Prevention and Control team in the home. The Infection Control Program was reviewed through Public Health Ontario and recommendations were made to develop a team to build the program. Upon interview, it was revealed that the home is working on developing the interdisciplinary team approach in the co-ordination and implementation of the Infection Prevention and Control Program. [s. 229. (2) (a)]

2. The licensee failed to ensure all pets living in the home or visiting as part of a pet visitation program had up-to-date immunizations.

Staff confirmed that St Johns Ambulance dogs were coming to the home, however, the record review revealed that the most recent immunization record was from 2004. Records confirmed that pets visiting as part of a pet visitation program did not have record of up-to-date immunizations.

The home's policy titled "Pets, Visiting", #A-07-I-50, and # QI-20-130 stated: Proof of annual vaccination of the pet must be presented annually. [s. 229. (12)]

***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 ensuring that there was an interdisciplinary team approach in the co-ordination and implementation of the Infection Prevention and Control Program and ensuring all pets living in the home or visiting as part of a pet visitation program had up-to-date immunizations, to be implemented voluntarily.***

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**WN #7: 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. (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 a resident's care was provided as set out in the plan of care.

A Resident was identified in the plan of care under continence, to require assistance with a potential to restore function to maximum self-sufficiency. The plan of care identifies a toileting schedule of regular routine times throughout the day.

Staff interview confirmed that the resident receives care in the morning upon waking and mid morning but no further care before the shift ends.

This resident was not observed to be toileted at the times indicated on the plan of care.

A Resident was not provided care as per the plan of care related to the established toileting schedule. [s. 6. (7)]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,  
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

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**Findings/Faits saillants :**





1. The licensee failed to ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

A Resident is frequently incontinent of urine at night according to the plan of care, Minimum Data Set (MDS), and interview.

There is no evidence of a Continence Assessment for this resident on Point Click Care. An interview was conducted with the Director of Care who confirmed that there has not been a Continence Assessment done on this resident. [s. 51. (2) (a)]

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**WN #9: 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. (4) The licensee shall ensure that,**

**(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).**

**(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).**

**(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).**

**(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).**

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**Findings/Faits saillants :**



1. The Licensee failed to ensure that the results of the survey are documented and made available to the Residents' Council and the Family Council to seek their advice under subsection (3)

According to an interview with the Administrator, the annual satisfaction survey is handed out to residents in the month of March. The results are usually available in May or June of the same year. The Family Council meeting minutes were reviewed for the months of May, 2013 and September, 2013. There was no entry in the minutes of these meetings to confirm discussion about the Annual Satisfaction Survey results. The Administrator confirmed that the results of the 2013 Annual Satisfaction Survey were not shared with the Family Council. [s. 85. (4) (a)]

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

**Specifically failed to comply with the following:**

**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,  
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).**

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**Findings/Faits saillants :**



1. The licensee failed to ensure that procedures are implemented for addressing incidents of lingering offensive odours.

The home policy titled "Offensive Odours", dated as reviewed May 2013, indicates that the home will endeavour to control or eliminate any offensive odours by ensuring waste is emptied regularly and disposed of properly, all soiled linen is removed and taken to the laundry room and by using a deodorizer product that is conducive to the environment.

During the morning, a Long Term Care Homes Inspector noted an offensive odour upon entering a home area. Staff interviewed at the time were unable to identify the cause of the odour. The linen cart was observed to be outside the tub/shower room.

During the afternoon, a Long Term Care Homes Inspector noted an offensive odour upon entering home area. The linen cart was observed to be outside the tub/shower room.

A day later it was noted that an offensive odour was present upon entering a home area. The laundry hamper was noted to be positioned outside the tub/shower room and the container used for soiled incontinence products was noted to be half full. Interview with a staff member confirmed that soiled continence products were in the linen cart. Upon exiting the home area approximately twenty minutes later the odour continued to be present outside the tub/shower room and extending down the corridor toward the exit.

The licensee failed to comply with their policy related to Offensive Odours as the odour was evident on multiple occasions in the same area. The waste container had not been emptied to assist with minimizing odours, no deodorant product had been used to address the odour in this home area. [s. 87. (2) (d)]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90.  
Maintenance services**



Specifically failed to comply with the following:

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,  
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that procedures were developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

Observations made with the maintenance staff revealed that grab bars in a shower room were corroded and the electric heating panel in a tub room was badly rusted . A brown edge around a toilet was observed in a tub room.

In a resident's room, the drain in the bathroom sink was noted to be corroded and rusted.

The Maintenance staff confirmed that they do not check the tub rooms or the shower rooms on a regular basis to ensure the equipment is maintained and kept free from corrosion and cracks.

The home's policy titled "Shower Equipment", # M-VII-130, stated: Shower equipment is to be operationally checked on a regular basis to ensure equipment is maintained in proper working order. [s. 90. (2) (d)]

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.**

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**Findings/Faits saillants :**



1. The licensee failed to ensure that there are written procedures required under section 21 of the Act that incorporate the requirements set out in section 101.

The home's policy titled "Resident/Family Complaint/ Resolution Procedure", dated as reviewed in March 2013, # A-07-II-55, indicated that management may decline to investigate a complaint based on the timeliness of reporting. Legislation under O.Reg. 79/10, s.101(1) requires that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with. [s. 100.]

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information**

**Specifically failed to comply with the following:**

**s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:**

**1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).**

**2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).**

**3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).**

**4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).**

**5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).**

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**Findings/Faits saillants :**

1. The licensee failed to post the most recent audited reconciliation report.

The Admission Process checklist and interview confirm that the most recent audited reconciliation report was not posted in the home. [s. 225. (1) 3.]



**Ministry of Health and  
Long-Term Care**

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

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

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

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**Issued on this 15th day of April, 2014**

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