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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 7, 2016	2016_189120_0031	027745-15, 028622-15, 032900-15	Complaint

Licensee/Titulaire de permis

PARKVIEW MEADOWS CHRISTIAN RETIREMENT VILLAGE
72 Town Centre Drive Townsend ON N0A 1S0

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

GARDENVIEW LONG TERM CARE HOME
72 Town Centre Drive Townsend ON N0A 1S0

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 26, 27, 2016

Complaint items reviewed included:

027745-15 - shortage of and cleanliness of slings for mechanical lifts, supervision of resident accessible outdoor spaces.
028622-15 - shortage of gloves and floor lifts
032900-15 - no hot water for approximately 4 hours on November 12, 2015 between 1800 and 2150 hrs.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Environmental Services Supervisor, registered staff, non-registered staff, laundry, maintenance and housekeeping staff.

During the course of the inspection, the inspector toured the home, supply storage rooms and enclosed outdoor area, tested stairwell door looks and alarms, tested mechanical floor lifts for function, observed the number and condition of slings, the availability of gloves and mechanical floor lifts, observed the use of mechanical floor lifts, reviewed maintenance records for mechanical floor lifts and slings, housekeeping routines and cleaning procedures, the clinical record for one identified resident and emergency procedures and contingency plans for loss of essential services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. 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,
(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; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were developed and implemented for cleaning of the home, specifically the floors.

During the inspection on May 26 and 27, 2016, approximately 40% of the flooring material in resident rooms and ensuite bathrooms were observed to be black in appearance and the wax layer was worn down in specific high traffic areas. The resident rooms on the second floor were provided with "no-wax" one piece sheet vinyl flooring material which was coated in a layer of wax and the first floor had hard vinyl square tiles which were waxed. The floors were also very sticky, causing the inspector's shoes to stick to the floor and caused two minor tripping incidents. According to a housekeeper, a disinfectant/cleaner was used to clean the floors which was automatically mixed with water from an automatic dispenser. The stickiness was identified to have been related in part to the use of the identified product which may or may not have been ideal for the flooring material or adequately diluted. The housekeeping manager had trialled other floor cleaning products in the past, but the product also contained a disinfectant. A neutral floor cleaner was not offered as an option. She was not aware that a disinfectant/cleaner was not required on general floor surfaces for infection control purposes and reported that her chemical supplier recommended the products.

The licensee's cleaning policy did not include any information regarding floor care with the exception of daily cleaning using a "germicide". No information was available in the procedure to direct housekeeping staff as to how to care for the various different types of flooring material, what equipment would be necessary to maintain them, the frequency of buffing, stripping and re-waxing and the appropriate cleaning agents necessary to keep the floors clean in appearance, sealed as necessary, stain and scuff-free and free from stickiness. According to general floor manufacturer's of vinyl sheet flooring, the material is sold with either no finish, a urethane or enhanced urethane finish which do not require waxing or buffing. The manufacturer's also suggested the use of a rinse free (residue-free) hard surface cleaner (without disinfecting ingredients).

The maintenance person interviewed reported that the flooring material on the first floor was stripped and re-waxed by in home staff approximately 6 months prior and that one layer of wax was applied. No buffing routine had been added. Another maintenance person reported that the second floor bedrooms were in fact coated in a layer or more of wax and no buffing schedule in place. The licensee therefore did not develop a floor care program specific to the flooring needs of the home. [s. 87. (2) (a)]

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 procedures are developed for cleaning and maintaining the floors in the home, to be implemented voluntarily.

WN #2: 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. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written policy that dealt with when doors leading to secure outdoor areas would be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

In the fall of 2015, an identified resident was found by a staff member in the outdoor secured garden area lying on top of a bush. The resident was not identified with any injuries upon assessment. According to records completed by registered staff on the date of the incident, the resident was alone, without proper footwear and without their walker. The resident exited via one of 2 doors that lead to the outdoor courtyard from a home area on the ground floor. Each door was located near the end of a long corridor and recessed so that they could not be seen by any one at the nurse's station. The courtyard was designed with a smooth concrete walk way from one door the the second with a grassy area on each side with some bushes. A perimeter of rocks had been removed after the incident. During the inspection, both courtyard doors were unlocked and the outdoor temperature was over 30C and very sunny. No written policy could be provided by the Director of Care, Environmental Services Supervisor or the Administrator with respect to when the residents were and were not to be permitted or were restricted from accessing the outdoor space. Discussion held regarding concerns related to the level of cognition of residents in the home area on the ground floor and undetected access to the outdoor space. Staff awareness and periodic monitoring throughout periods of time when the doors would be left unlocked would be required. According to a maintenance person, the general routine was to unlock the doors between 7-8 a.m. and lock them between 8-9 p.m. on days when the weather was favourable and closed during winter months. According to the Director of Care, staff working in the home area were required to look out into the courtyard periodically to monitor residents. [s. 9. (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 to ensure that a written policy that deals with when doors leading to secure outdoor areas would be unlocked or locked to permit or restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (5) The licensee shall ensure that the emergency plans address the following components:
1. Plan activation. O. Reg. 79/10, s. 230 (5).
2. Lines of authority. O. Reg. 79/10, s. 230 (5).
3. Communications plan. O. Reg. 79/10, s. 230 (5).
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

Findings/Faits saillants :

1. The licensee did not ensure that the emergency plans addressed the following 3 components:

2. Lines of authority. 3. Communications plan. 4. Specific staff roles and responsibilities.

On November 12, 2015, the home's maintenance person (#001) shut off the hot water to the long term care home to conduct repairs beginning at 6 p.m. According to maintenance person #001, a written memo and verbal communication were provided to registered staff and personal support workers who worked on the evening shift that the hot water would be off for less than a few hours. Further communication was provided by a maintenance person (#002) who worked in the retirement home in the adjoining building that personal support workers could fill up the bath tubs with hot water should it be required for any resident care. Unfortunately, the hot water would not have remained very hot after 30 minutes. Upon completing the repair, maintenance person #001 left the building and forgot to turn the hot water system back on. Registered staff contacted management staff about the delay and the hot water system was turned back on at 9:50 p.m. An anonymous complaint was received by a staff member several days later reporting how resident care was provided due to the lack of hot water and the details were reflective of the instructions given by maintenance staff #002. The complainant left information as to how they had filled up their wash basins from the stored water in the tub to use on residents for evening care. Unfortunately, the direction was not appropriate for infection control reasons and staff should not have been using any stored water from the tub to complete resident care. It appeared that no direction was given to staff related to the use of disposable wipes, which were confirmed to be available at the time of inspection. According to the Director of Care, disposable wipes were also available on November 12, 2015 and that personal support workers were aware of how to use them.

The licensee's loss of gas and heat and loss of water contingency plans were reviewed dated September 2005. Neither contingency included any detailed information for nursing staff regarding the continuation of care for residents when no hot water or when a lack of water was available. The loss of water service plan included that "resident bathing be restricted", "stored water from tubs and sinks be used to flush toilets" and the "distribution of germicidal waterless soap to all departments". The plan lacked lines of authority (who would report to whom to provide direction), a communications plan (how staff, visitors, residents and relevant agencies would be informed, when and what information would be provided and by whom) and specific staff roles and responsibilities for each department. [s. 230. (5)]

Issued on this 9th day of June, 2016

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

Original report signed by the inspector.