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
Feb 21, 22, 2012	2012_072120_0019	Other

Licensee/Titulaire de permis

WATERDOWN LONG TERM CARE CENTRE INC.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

ALEXANDER PLACE
329 Parkside Drive, P. O. Box 50, Waterdown, ON, L0R-2H0

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 an Other inspection.

During the course of the inspection, the inspector(s) spoke with the administrator, environmental services supervisor, registered and non registered staff and residents.(H-000367-12)

During the course of the inspection, the inspector(s) toured all home areas, resident rooms, the laundry room, utility rooms, dining rooms, and reviewed policies and procedures.

The inspection was conducted in conjunction with the Resident Quality Inspection H-000214-12.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Accommodation Services - Maintenance

Infection Prevention and Control

Safe and Secure Home

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. 89. Laundry service

Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

[O. Reg. 79/10, s.89(1)(a)(iii)] Procedures have not been developed and implemented to ensure that all resident's soiled clothes are sorted prior to cleaning. During a tour through the home, 3 to 4 residents were noted to have a red bag in their room or washroom with personal clothing and other linens inside. According to laundry staff interviewed, the red bags are brought to laundry and directly loaded into the washing machine, without being sorted, regardless of the wash instructions for the various different types of materials in the bag. The current laundry policies and procedures developed by Superior (contracted service) require that clothing and linens be collected and stored in one bag and not sorted prior to cleaning for residents who have been diagnosed with a communicable organism. Clothing from residents who have not been diagnosed with a communicable organism was observed to be sorted prior to cleaning as required and placed into washing machines programmed for the type of clothing or linen being washed.

The home's laundry handling instructions under the infection prevention and control program states that laundry from residents with a communicable organism such as MRSA or VRE does not require "special handling". Therefore, laundry from these residents is to be sorted prior to cleaning as it is being done for other residents in the home.
2. [O. Reg. 79/10, s.89(1)(c)] Bath towels are not kept in a good state of repair and face cloths are not free from stains. Approximately 4 bath towels were pulled from circulation which were frayed around the edges and a number of stained face cloths were pulled from resident rooms and linen storage rooms. A resident pulled several face cloths from her room and was upset about the stains in them and provided them to an inspector. A review of the laundering process was conducted and through observation it was noted that laundry staff do not adequately assess the condition of linens once they are removed from the dryers. The contracted laundry service provider by the name of Superior, has policies and procedures which directs laundry staff to assess linens in the laundry room while they are being folded, however it was observed that the folding process has been eliminated. Laundry staff do not fold linens and instead they stuff the linens into bags before delivering the bags to the various home areas. Personal support workers confirmed that they fold linens in the various home areas and they do not discard stained and worn items. In some cases, residents assist with the folding and are not required to assess linen condition. No details have been provided in the procedures as to what criteria staff should use to discard linens.

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 resident's soiled clothes are sorted prior to cleaning, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. Not all hazardous substances are kept inaccessible to residents at all times. The following hazardous products were found in resident accessible areas:

1. A spray bottle of "Speedball Heavy Duty Cleaner" was found in a resident washroom on the bathroom counter on February 21, 2012. This product is used by housekeeping staff when cleaning bathrooms.
2. A spray bottle of "Urine Off" was found inside of a bathroom cabinet in a resident washroom on February 21, 2012. This product was used by nursing staff to control urine odours in resident washrooms.
3. A spray bottle of Lysol with bleach was found on the floor of a resident's bathroom on February 22, 2012. This product belongs to the resident and was not identified by any staff member during cleaning routines or during routine room audits.
4. A housekeeping cart in house 300 was noted to have 2 spray bottles, "Speedball" and an Odour neutralizing solution hanging off the side of the cart on February 22, 2012. The housekeeper was noted to be mopping the floor and had her back to the cart and did not notice that the bottles were being removed.

The home has a policy that cleaning products are to be locked in the soiled utility room, janitor room or the housekeeping cart and that resident owned items are assessed and residents provided with a locked cabinet.

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 hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #3: 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 subsections:

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 :

Staff do not all participate in the implementation of the infection prevention and control program.

As part of the home's infection prevention and control program, staff are required to clean and disinfect plastic ware and shower chairs after each use as per their policy titled "Cleaning Procedure for Nursing Care Equipment". Observations made during the inspection confirm that the disinfection of re-usable plastic ware such as bedpans and washbasins and the disinfection of shower chairs after each use did not occur.

No disinfectant was used on a shower chair in the 200 home area after a resident was showered in 2012. None of the shower rooms had any disinfectant located in them and staff were expected to get the disinfectant from either a locked utility room or linen room. Only 1 home area had disinfectant available to staff in a linen room which was located in a bottle labeled as disinfectant. The other home areas had either no bottles, bottles that were unlabeled or labeled as D10, a sanitizer for food preparation surfaces.

Washbasins and bedpans, according to the home's policy, are required to be taken to the soiled utility room on the home area and cleaned and soaked in disinfectant after each use. The soaking would take place in the home's soiled utility room sinks. The soiled utility rooms in each home area were observed to be in use for the storage of various items, soiled laundry and the use of the hopper. The rooms were overly cluttered, counter tops full of items, preventing staff from being able to conduct any cleaning in the rooms. No disinfectant was available in any of these rooms. The rooms remained unused for cleaning purposes over a two day period. No policy could be located that describes what type of and how much of the disinfectant versus water to use, how to soak the items, how to wash the items and where and how to dry the items.

Washbasins, according to staff are washed with soap and water in the resident's bathroom and placed back in their cabinets. Observations were made during the inspection of 5 randomly selected washbasins stored in resident washroom cabinets. The washbasins were noted to contain clear water in them, an indicator that the basins had just been either cleaned/rinsed or just rinsed. Disinfectant is not used according to various staff members and the fact that disinfectant spray bottles were not located anywhere within the home area supports that items are not disinfected. When staff were asked to locate the disinfectant sprays in one home area, none could be found.

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 #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 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 :

[O. Reg. 79/10, s.15(2)(c)] The licensee has not ensured that the home is in a safe condition and in a good state of repair. The flooring material in the shower room located in the 200 home area was identified to be in a poor state of repair and as a result, potentially creating an unsafe condition. Two different types of flooring material are currently in the shower room. The dark pink vinyl material has a repaired seam in it which has split. There is also a crack in the material along the wall/floor junction near the shower area. When the flooring was stepped on near the drain, odourous water squirted out from under the material, near the transition point where the second type of flooring meets the pink vinyl. The accumulation of water under the flooring material can cause uneveness in the floor, contributes to odours and may cause the growth of mould under the flooring.

Issued on this 23rd day of April, 2012

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

B. Susnik