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

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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
Dec 5, 2013	2013_239503_0004	T-533-13	Other

Licensee/Titulaire de permis

BAY HAVEN NURSING HOME INCORPORATED
499 HUME STREET, COLLINGWOOD, ON, L9Y-4H8

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

BAY HAVEN NURSING HOME
499 HUME STREET, COLLINGWOOD, ON, L9Y-4H8

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

LAURA BROWN-HUESKEN (503), STELLA NG (507), VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): December 4, 2013

During the course of the inspection, the inspector(s) spoke with Director of Care, Registered Nursing Staff, Food Services Supervisor (FSS), Activation Coordinator, Personal Support Workers (PSW), Residents

During the course of the inspection, the inspector(s) conducted tour of the home, reviewed clinical records, resident council minutes for September-November 2013, and the home's policies related to meal service, infection prevention and control, and internal complaints, and observed lunch meal service and the provision of care to residents.

The following Inspection Protocols were used during this inspection:
Dining Observation

Infection Prevention and Control

Residents' Council

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

On an identified date the door leading into the resident's bath tub room in the east wing of the home was observed to be propped open with a shower curtain. The room was unattended and the bath tub was filled with water. An interview with PSW #1 confirmed that the door should not be propped open when the room is unattended by staff. [s. 5.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

The home's menu for lunch on an identified date included Soup of the Day, a choice of two entrees and a choice of two desserts. Resident #001 was observed to arrive at an assigned table in the dining room after the table had been served the soup. In an interview, resident #001 indicated that the planned soup had not been offered and that he/she would have liked to have the soup dependent on the variety. An interview with PSW #2 confirmed that resident #001 had not been offered soup due to the resident arriving to the dining room after the resident's table had been served. The PSW #2 further stated that this was not consistent with the home's practices and was a staff mistake. The PSW #2 was then observed to offer resident #001 the soup of the day. [s. 71. (4)]

WN #3: 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. (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 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.

Resident #003's written plan of care directs staff to provide constant encouragement and physical assistance for eating and that resident #003 may need to be fed. On an identified date resident #003 was served soup. The resident was not observed to independently consume the soup. Resident #003 was not provided any physical assistance until the resident's entree was provided 15 minutes after the service of the soup. [s. 73. (2) (b)]

WN #4: 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.

On an identified date an identified Food Services Worker was observed removing soiled entree dishes from dining room tables and subsequently serving desserts to residents. The Food Services Worker did not wash or sanitize hands between these tasks. An interview with the FSS confirmed that this was not consistent with the Infection Prevention and Control program. The FSS stated that staff members are expected to either wash or sanitize their hands between removing soiled dishes and serving desserts. [s. 229. (4)]

Issued on this 9th day of December, 2013

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

L Brown-Hueston